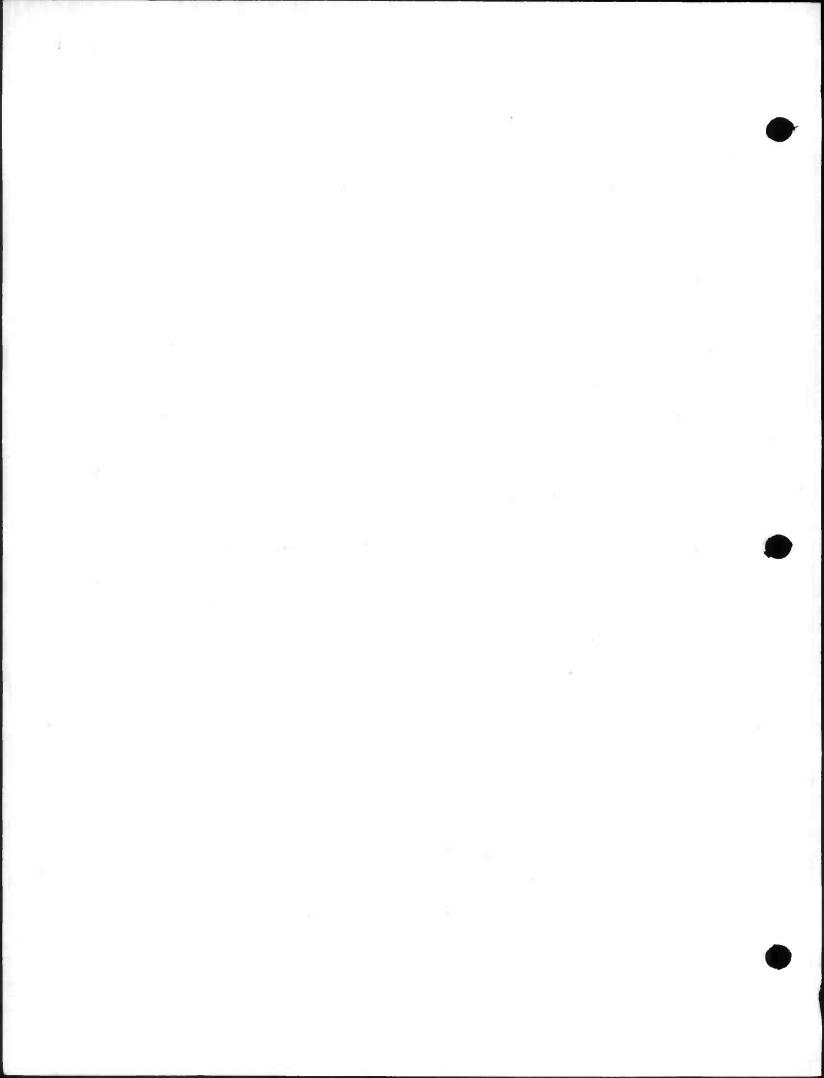
DIVISION OF VITAL RECORDS, P.O. BOX 6876

TO THE HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed whom 24 hours after death. Page 6 may be retained by the hospital or attending physician.	rificate has been signed by the attending physician and completely filled	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burnal, cremation, or removal.	MPORTANT: if item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
TO THE	TO THE	pe filed	IMPORT

	FOR 1 - STATE REGISTRAR	STATE OF MARYL	AND / DEPARTM				GIENE		
	1. DECEOENT'S NAME (First, Middle, Last)					2. DATE OF OEA	TH DAY	W=4.0	3. TIME OF DEATH
	JOSEPH	J.	SCAGLIA			Dec.	1995	YEAR	4:55P M
	The state of the s			UNDER 1 YEAR	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRT		8. BIRTH Count	IPLACE (State or Foreign
	120 03 1747	∭ M 2 ∏ F	87 YRS.	TINS DATS	HOURS MIN.	March 6			York
~	9a. FACILITY NAME (If not institution, give atreet				R LOCATION OF DE	ATH		NTY OF D	
DIRECTOR	Frederick Health	Care Cente	r	Fred	lerick		Fr	ede	rick
EC	10a. STATE 10b. COUNTY		10c. CITY, TO	OWN OR LOCAT	ION				10d. INSIDE CITY
E	Maryland Frederic	ck	Fred	erick					LIMITS?
	10e. STREET AND NUMBER			101.	ZIP CODE		t0g. CITI	ZEN OF	WHAT COUNTRY?
FUNERAL	5594 Teakwood Ct.,			21	.703		USA		
N N		. WAS DECEDENT EVER I	N U.S. ARMED		ENDENT OF HISPAN			14. RACI	E — American Indian, k, Whita, etc.
BY	1 Never Married 2 N Married 3 Widowed 4 Divorced	IF YES, GIVE WAR OR E			2 NO Specify:		,	Spec	illy:
	15. OECEDENT'S EDUCATION	ON	16a. OECEDENT'S USU	IAL OCCUPATIO	M	160 KIND (OF BUSINESS/INC	MISTEV	White
H	(Specify only highest grade com	college (1-4 or 5+)	(Give kind of work life. Do NOT use re	done during mos		too. Killo	, 500mE30/mo	OSTAT	
7	0	+	Factory F	oreman		Pepsi	Cola C	ompa	ny
COMPLETED	17. FATNER'S NAME (First, Middle, Last)				te. MOTHER'S NAM	ME (First, Middle, A	falden Sumame)		
BE 0	Carlo Scaglia				Mary Be	rnardi			
TO B	19a. INFORMANT'S NAME (Type/Print)		19b. MAILING AD	DRESS (Street a	nd Number or Rural A	loute Number, City	or Town, State, Zip	Code)	
F	Charlotte Scaglia		5594 Tea	akwood	Ct., Fre			703	
	20a. METHOO OF DISPOSITION 1 □ Burlai 2 ♣ Cremation 3 □ Removal		b. PLACE AND DATE OF D				Dc. LOCATION —		
	4 Donation 5 Other (Specify) 21, SIGNATURE OF FUNERAL SERVICE LICENS		netery, cremetory or other lagerstown						Maryland
	21. SIGNATURE OF FUNERAL SERVICE LICENS	rec .		ľ	D ADORESS OF FAC				
	Kauman 15	Pelen	an)possumto				t, MD 21702
	23. PART i. Enter the diseases, or com shock, or heart fallura. List	plications that cause t only one cause on	d the death. Do not each line.	anter the mo-	de of dying, such	n as cardiac or	respiratory arr	rest,	Approximata Intervai Between
	iMMEDIATE CAUSE (Final disease or condition	1	1 4.	,	1. (Onset and Death
	resulting in death)	DUE TO (00 40	A CONSEQUENCE PER	1 /	74-1.	9-			445
_	_ ;;;	DOE TO (OR AS	A CONSEMPENCE OF S.		/				
CERTIFICATION	Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF):								<u> </u>
CAT	r any, leading to immediata cause. Enter UNDERLYING								
Ĕ	CAUSE (Disease or injury that initiated events	DUE TO (OR AS	A CONSEQUENCE OF):						
EH	reaulting in death) LAST								
AL C	PART il. Other algnificant conditions co	ontributing to death	but not resulting in t	he underlying	causa given in l	Part i. 24s. W	AS AN AUTOPSY	248	. WERE AUTOPSY FINDINGS
S	CVA						PERFORMEO?		AVAILABLE PRIOR TO COMPLETION OF CAUSE
MEDIC							2 7 10		OF DEATN? 1 YES 2 NO
7	DID TOBACCO USE CONTRIB	UTE TO CAUSE (OF DEATH YES		UNCERTAIN	10			
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?		26. PLACE OF DEATH						
SIC		OSPITAL:		Nursing Nom	e 5 🗆 Realdanca	6 C Other (Speci	fy)		
H	27. MANNER OF DEATN	26e. DATE OF INJURY (Month, Day, Year)	26b. TIME O		URY AT RK?	26d. DESCRIBE	NOW INJURY OC	CURED	
В	1 Netural 5 Pending 2 Accident Investigation				rES 2 NO				
ED	3 Suicide 6 Could not be 4 Homicide determined	28a. PLACE OF INJUR building, atc. (Spi	Y — At home, ferm, stree ecify)	it, fectory, offici		28f. LOCATION (City or Town,	Street and Number , State)	or Rural	Route Number,
H									
COMPLET	onel	N: To the best of my know							
ő	2 MEDICAL EXAMINER: O	In the basic of examination	on and/or Investigation, I	n my opinion, d	eath occursed at the	time, data and pic	eca, and dua to th	ne Cause(a) and manner as stated.
BE (29b. SIGNATURE AND RITLE OF CERTIFIER	~ 67	1		29c. LICENSE NUM	IBER	29d. DAT	E SIGNE	(Month, Day, Year)
70	May	1 (- (/ · · ·	-70	1)/6	428	1	15	1191
	30. NAME AND ADDRESS OF PERSON WHO CO								
	CASPER E. CLIN 31. DATE FILED (Month, Day, Year)	E III	300 W. C	1th St	reet, Fc	alerick	MD a	2170	
	DFC 08 1995	Julia de	Will Rarball				,		

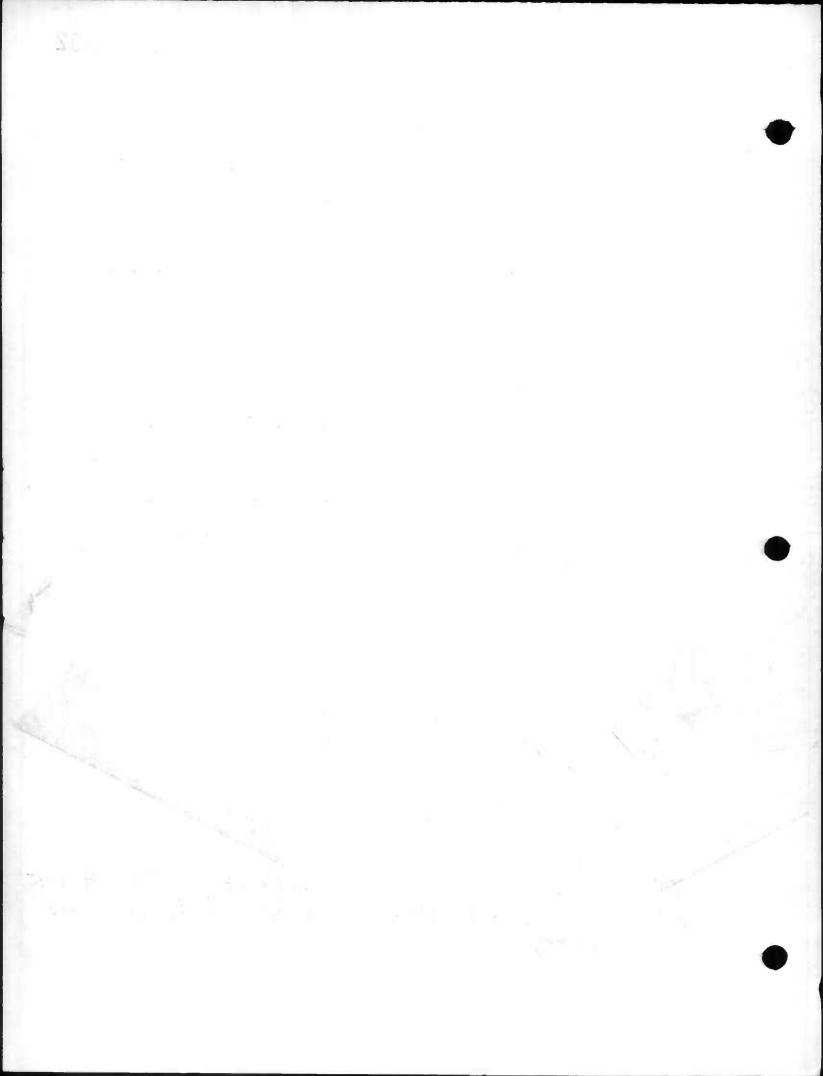


DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. or Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	1 - STATE OF MARY	LAND / DEPARTM CERTIFIC			MENTAL	HYGIENE REG. NO.					
,	1. DECEDENT'S NAME (First, Middle, Last)				2. DATE O		VF	3. TIME OF DEATH			
	411000	Sanders			December 2, 1995			5 11:50 PM			
		MO	MONTHS DAYS HOURS MIN.			Day, Year)		BIRTHPLACE (State or Foreign Country)			
	218-07-9037 1 [X M 2] F	75 YRS. 96	L CITY, TOWN O	R LOCATION OF DE		19,192	9c. COUNTY	OUZERVILLE, PA			
DIRECTOR	FREDERICK MEMORIAL HOSPITAL		FREDERI	CK			FREDE	ERICK			
JEC	10e. STATE 10b. COUNTY	10c. CITY, TO	OWN OR LOCATI	ON				10d. INSIDE CITY LIMITS?			
	MARYLAND WASHINGTON	CAS	CADE					1 X YES 2 NO			
FUNERAL	BOX 245 MILITARY RD.			1719			U. S.	ο of what country?			
N N		R IN U.S. ARMED		NOENT OF HISPAN	IC ORIGIN	(Specify Yes		BACE — American Indian			
	11. MARRITAL STATUS 1 X Never Married 2 Married 12. WAS DECEDENT EVER FORCES? 1 X YE IF YES, GIVE WAR OR	DATES	If yes, spe	city Cubers, Mexican 2 [X NO Specify	n, Puerto R	Ican, etc.)		Black, White, etc.			
D BY	3 Wildowed 4 Divorced WW I				Low			WHITE			
=	15. DECEDENT'S EDUCATION (Specify only highest grade completed)	(Give kind of work life. Do NOT use re	done during mos			KIND OF BUS					
3	Elementary/Secondary (0-12) College (1-4 or 5 +)	PRESSER			- Care		LEANI				
COMPLETED	17. FATHER'S NAME (First, Middle, Last)			18. MOTHER'S NAI	,		Surname)				
BE	WILLIAM FRANCIS SANDERS			IDA	SIT						
10	180. INFORMANT'S NAME (Type/Print) MARIE BEALL			OD CT.,							
	One METHOD OF DISDOSITION	Ob. PLACE AND DATE OF D			DATE			or Town, State			
	1 Donation 5 Other (Specify)	NEW ST. JO	SEPH'S	12/6/95	5	EMMI	TSBURG	G, MD. 21727			
	21. SIGNATURE OF FUNERAL SERVICE LICENSES. M. Shills			D ADDRESS OF FA	CH ITTY			RAL HOME			
	I form M. shites		210 W.	MAIN ST				MD. 21727			
	23. With I. Enter the disease, or complications that ceus shock, or heart feliure. List only one cause or IMMEDIATE CAUSE (Final disease or condition resulting in death)	aech line.		C. 11. 40. 41. 11.				Interval Between			
ATION	IMMEDIATE CAUSE (Final disease or condition resulting in death) a. Head and head Squamous Cell Garcinoni 8 mos. Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):										
CERTIFICATION	CAUSE (Disease or Injury that initiated events resulting in death) LAST C. Due TO (OR AS A CONSEQUENCE OF):										
AL C	PART II. Other algnificant conditions contributing to deat	n but not resulting in t	the underlying	cause given in	Part I.	24a. WAS AN PERFOR		24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO			
MEDIC	Hypercalcemia						1 YES 2 NO OF DEATH?				
	DID TOP ACCOUNT CONTRIBUTE TO CALLE	OF DEATH VEC		CUNICERTAIN				1 TYES 2 TO NO			
PHYSICIAN:	DID TOBACCO USE CONTRIBUTE TO CAUSE 25. WAS CASE REFERRED TO MEDICAL	26. PLACE OF DEATH		UNCERTAIL	и Ц	_					
SICI	EXAMINER? 1 YES 2 NO 1 Inpatient 2 ER/O	- 0	THER:	e 5 🗆 Residence	5 Othe	r (Specify)					
ΉΥ	27. MANUER OF DEATH 250. DATE OF INJUR	RY 28b. TIME C	OF 28c. INJ	URY AT		CRIBE HOW I	NJURY OCCUP	RED			
ВУР	1 Naturel 5 Pending (Month, Day, Year) INJURY WORK? 2 Accident Investigation										
	2 Accident 3 Suicide 6 Could not be determined 28e. PLACE OF INJURY — At home, farm, street, factory, office building, aftc. (Specify) 28f. LOCATION (Street and Number or Flural Floute Number, City or Town, State)										
COMPLETED	29e. CERTIFIER (Check only one) 2										
Ö	THE ADMATURE AND TITLE OF CERTIFIER	-		29c. LICENSE NUI	MBER		29d. DATE S	SIGNED (Month, Pay, Year)			
TO BE	LALL MSD			D 26	516		▶ D	EC 4 1995			
-	30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF	DEATH (ITEM 27) (Type, Pr	TMI	Y An		FRE	ED 1	m 2.1702			
	31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S S	IGNATURE	Porte	/ IN		1 /		9 011			
	DEC 0 8 1995 Julia de	Ruchar Road H	4								



68760
BOX
P.0.
ECORDS,
OF VITAL R
OF
VISION

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If them 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

29b. SIGNATURE AND TITLE OF CERTIFIER

31. DATE FILED (Month, Day, Year)

1. 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

1995

32. REGISTRAN'S SIGNATURE

Awardson-Rardall

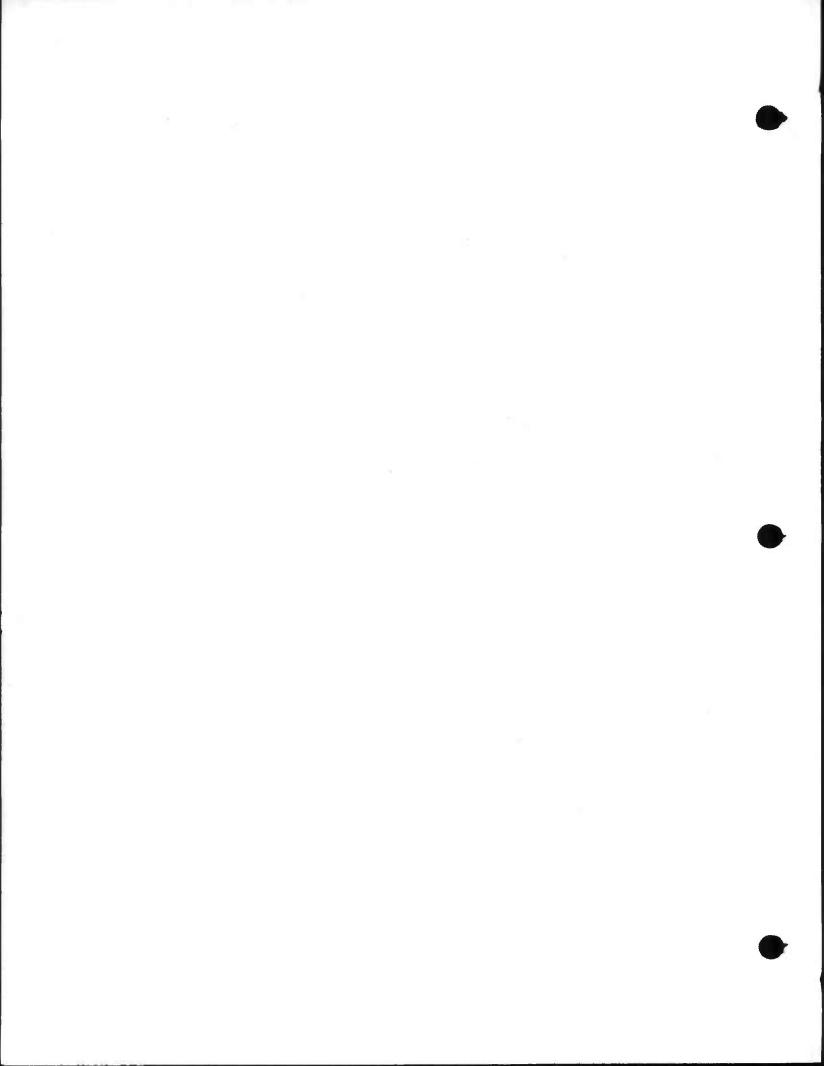
TO BE COMPLETED BY FUNERAL DIRECTOR

									90	00	000
FOR	CTATE OF M	IADVI AND I							_		
1 - STATE REGISTRAR	STATE OF M	IAKYLANU /	DEPARI ERTIFIC	MENT	OF RE	ALTH AND	MENT	AL HYGIEN REG. NO.	E		
1. DECEDENT'S NAME (First, Middle, Las	n	- 0.		DAIL	. OI D	LAIII	2. DAT	E OF DEATH			3. TIME OF DEATH
Vada Vic	ola s	Stottle	emyer				Dec	TH DA	1995	VEAR	6:56 pm
4. SOCIAL SECURITY NUMBER	5. SEX	8. AGE (In yrs. les		IF UNDER	1 YEAR	F UNDER 24 HRS.		E OF BIRTH	100.		PLACE (State or Foreign
216-40-8039	1 🗆 M 2 💢 F	52	YRS.	IONTHS	DAYS H	OURS MIN.	Aud	1 12 1	0/12	Country	
9e. FACILITY NAME (If not institution, give	street end number)		1	9b. CITY,	TOWN OR	LOCATION OF E	_	1 1 1		NTY OF DE	ryland
6206 Dickerson	Rd.					rson					omery
RESIDENCE OF DECEDENT									110	Jireg	omer y
MD Mont	gomery		Dic. CITY,		R LOCATION	1					10d. INSIDE CITY LIMITS?
			Dic	иет							1 TYES 2 NO
100. STREET AND NUMBER 6206 Dickerson	Бд					842					HAT COUNTRY?
										5.A.	
11. MARITAL STATUS 1 Never Married 2 Merried	12. WAS DECEDENT FORCES? 1	EVER IN U.S. AR	MED NO	13. V	MAS DECEN	DENT OF HISPA y Cuben, Mexic	NIC ORIG	N? (Specify Yes	or No	14. RACE Bleck.	- American Indian, White, etc.
3 Widowed 4 Divorced	IF YES, GIVE W	AR OR DATES				NO Speci		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		Specify	
15. DECEDENT'S ED	UCATION	180 DE	CEDENT'S U	SIIAL OO	CHBATION		1100	P NING OF THE	1	HATT:	***************************************
(Specify only highest gra-	de completed)	(G	ive kind of wor Do NOT use	rk done d	luring most o	f working	18	b. KIND OF BUS	INESS/IND	USTRY	
Elementary/Secondery (0-12)	College (1-4 or 5 +)	reta	,			1.0	nt-	Co	C = 1-	1-
17. FATHER'S NAME (First, Middle, Last)		1360	reta.	т У	1	MOTHER'S M		ontq. Middle, Malden		SCN	DOTE
Herman Fitzwa	tor cr				- 1				эшттепте)		
19e. INFORMANT'S NAME (Type/Print)	cer, br.		b. MAJLING A	DDRESS	(Street and	Number of Burni	Bourto Mur	illers	State Zin	Code	
Carlton E. Sto	ttlemwer										24702
20e. METHOD OF DISPOSITION			ANDDATEOF							City or Tow	
1 Suriel 2 Cremetion 3 Re 4 Donation 5 Other (Specify)	moval from State	cemetary, cre	matory or other	er place!			1	5 Boy			n, sune
21. SIGNATURE OF FUNERAL SERVICE I	JCENSEE	воуиз	Pre	22. N	LET T	ADDRESS OF F	ACILITY	2 IROA	as,	MD	
will: C	11:1+				Hilt	on Fu	nera	l Hom	6		
23. PART I. Entar the diseases, or	Jun			1							
23. PART I. Entar the diseases, or shock, or heart failure	complications that List only one caus	caused the de sa on aach iina	ath. Do no	t antar t	tha moda	of dying, au	ch aa ca	diac or respi	ratory arr	est,	Approximata interval Between
IMMEDIATE CAUSE (Final				•	^						Onset and Death
disease or condition resulting in daath)	. m	かかれて	~	Bre-	1 0	nun					71 year
	DUE TO	OR AS A CONSEC	DUENCE OF):								
Sequantially list conditions,	b										
if any, leading to immediate cause. Enter UNDERLYING	DUE TO	OR AS A CONSEC	DUENCE OF):								
CAUSE (Disease or injury	C	OR AS A CONSEC									
that initiated events reaulting in death) LAST	000 10 (OH AS A CONSEC	DUENCE OF):								
150001000000000000000000000000000000000	d										
PART II. Other algnificant condition	ona contributing to	death but not n	esulting in	the unc	derlying c	ause givan in	Part i.	24a. WAS AN		24b.	WERE AUTOPSY FINDINGS
								PERFOR			WAILABLE PRIOR TO COMPLETION OF CAUSE
								1 TYES 2	SONO		OF DEATH?
DID TOBACCO USE CON	TRIBUTE TO CAL	JSE OF DFA	TH YES	ПМ	10 12	UNCERTAI	ΝП				I TYES 2 NO
25. WAS CASE REFERRED TO MEDICAL			E OF DEATH				- 1 🖵				
EXAMINER? 1 YES 2 QNO	HOSPITAL:	ER/Outpatient 3		THER		Residence	A TOP	er (Specific)			
27. MANNER OF DEATH	28e. DATE OF	INJURY	28b. TIME (OF :	28c. INJURY	AT	1	SCRIBE HOW IN	JURY OCC	URED	
1 Natural 5 Pending	(Month, Da	y, Year)	INJUR	M	WORKS						
2 Accident Investigation 3 Suicide 8 Could not be	28e. PLACE OF	INJURY — At ho	me, term, atre	ret, facto			28f. LO	CATION (Street e	nd Number	or Rural Pin	ute Number
4 Homicide determined	building, e	rtc. (Specify)					City	or Town, State)			
29e. CERTIFIER 1 NOCERTIEVING PHY	SICIAN: To the best -4 -	mu knowleden 4	ath age :								
(Check only one) 2 MEDICAL EXAMIN	HER: On the beele of ex										
	-1		vestyetton,	my op	mnuri, death	Account BE THE	time, dat	end place, end	aue to th	e cense(e)	end manner ee stated.

29c. LICENSE NUMBER

ARTHUR S. MANACO MD 187 THOMAS JOHNSON DR #3 FREDERICK MD 21702 301 894 7789

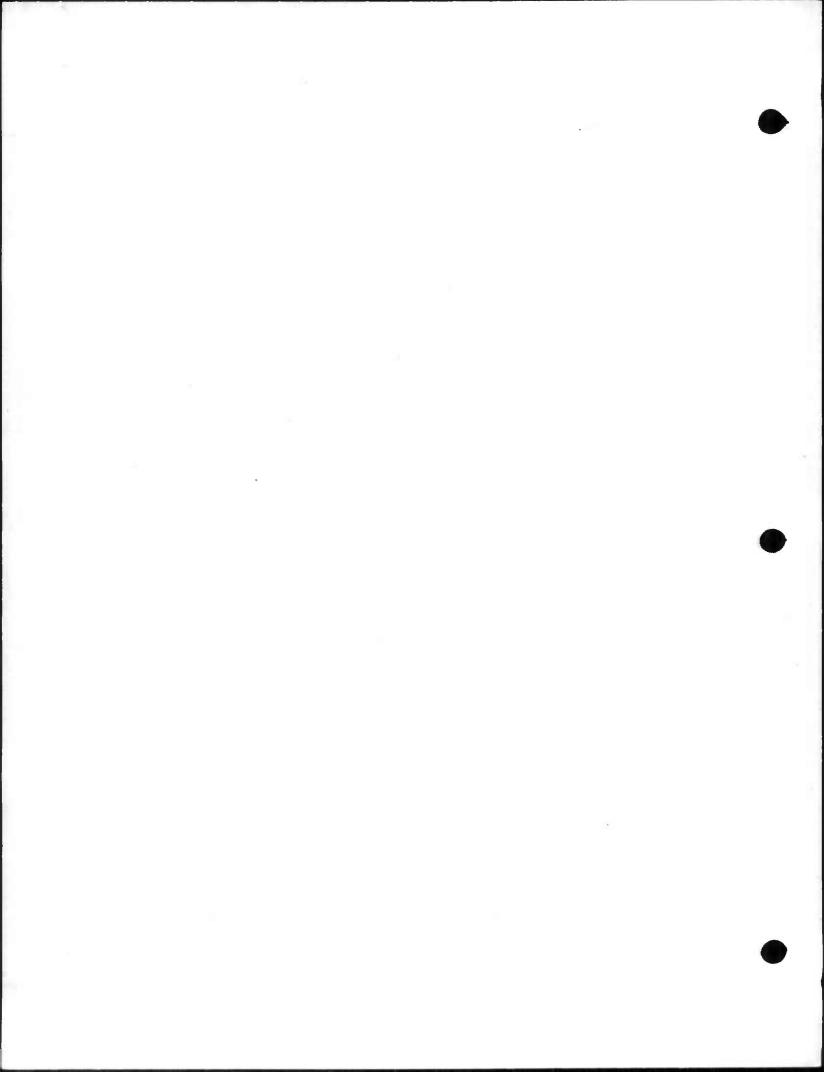
29d. DATE SIGNED (Month, Day, Year)



DIVISION OF VITAL RECORDS, P.O. BOX 68760

FOR 1 - STATE

	REGISTRAR		CERTIF	ICALE	OF DEA	IH	REG. NO).		
	1. DECEDENT'S NAME (First, Middle, Lest)					T	2. DATE OF DEATH		3. TIME OF DEATH	
	Elsie	SMITH				November 28, 1995 12				
- 1	4. SOCIAL SECURITY NUMBER		(In yrs. last birthday)	IF UNDER 1 Y	EAR IF UNDER	R 24 HRS.	7. DATE OF BIRTH		B. BIRTHPLACE (State or Foreign	
- 1	220-09-5394	Ol YRS.	MONTHS D	AYB HOURS	MIN.	May 3, 18	94	Country) Maryland		
	9e. FACILITY NAME (If not institution, give s	_	COUNTY OF DEATH							
02	Homewood Retireme			90. 0111, 10	CITY, TOWN OR LOCATION OF DEATH Frederick			9c. COUN	Frederick	
6	RESIDENCE OF DECEDENT	THE CONTOCT				TICU	CIICK		TICACTICA	
<u></u>	10e. STATE 10b. COUNT	Υ	10c. CIT	Y, TOWN OR L	OCATION			-	10d. INSIDE CITY	
DIRECTOR	Maryland E	Frederick			Freder	ick			LIMITS?	
	10e, STREET AND NUMBER				10f. ZIP COD	NE .		T 40 - 01717	1 ☑ YES 2 ☐ NO	
FUNERAL	21 Wort Datwick	Chuoch			101. 21P COD	217	01	10g. Ci 112		
2	31 West Patrick	12. WAS DECEDENT EVER			<u></u>				U.S.A.	
교	1 Never Married 2 Merried	FORCES? 1 YES	2 WNO				ORIGIN? (Specify Ye Puerto Rican, etc.)	e or No—	14. RACE — American Indian, Black, White, etc.	
₩	3 Wildowed 4 Divorced	IF YES, GIVE WAR OR I	DATES 21	1 🗆	YES 2 NO	Specify:		- 1	Specify: White	
۵	15. DECEDENT'S EDU	CATION	16a. DECEDENT'S	1101141 0001	047:011					
H	(Specify only highest grade	completed)	(Give kind of a	work done durie	PATION og most of worki	ng	166. KIND OF BU	SINESS/INDU	JSTRY	
1 2	Elementary/Secondary (0-12)	College (1-4 or 5+)							••	
once.	17. FATHER'S NAME (First, Middle, Last)	1	Homen	aker					Home	
5 0		1.5			18. MOT		E (First, Middle, Meiden			
B B	Charles E. Nichol	LS							nneberger	
other traumatic event, the medical examiner must be notified at once. TIFICATION TO BE COM							ute Number, City or Tow			
90	Catherine V. Smit	:h	8840	Stauf	ter Rd	., Wa.	lkersvill	e, Md	. 21793	
100	20e. METHOD OF DISPOSITION 11/2 Burlel 2 Cremetion 3 Rem		b. PLACE AND DATE of metery, crematory or of		N (Name of		DATE 20c. LC	CATION — C	City or Town, State	
Ē	4 □ Donation 6 □ Other (Specify)	Mo		ret. Cer	neterv	Dec	1, 1995	Frederick, Md.		
e l	21. SIGNATURE OF FUNERAL SERVICE LIC	CENSEE /		22. NAI	E AND ADDRE	SS OF FACI	LITY			
Wa.	Vallend, (.	C. Mako	L_M0002	Kee	ney and	d Bas:	ford Fune	ral H	ome	
2	23. PART I. Enter the diseases, or o	complications the bound		ITOO	East (churc	n Street,	Fred	erick, Md. 217	
9	ahock, or heert fallure.	List only one ceuse on	eech ilne.	iot enter the	mode or dy	ing, such	as cardiac or reap	iratory arre	eat, Approximata interval Between	
9	IMMEDIATE CAUSE (Final disease or condition	_							Onset and Death	
÷.	resulting in death)	· Yu		-0-17					2 days	
eve	DUE TO (OR AS A CONSEQUENCE OF):									
를 N	Sequentially ilst conditions,	b								
ry, or other traumatic	If any, leading to immediate									
F 3	CAUSE (Disease or injury	С.								
\$ E	that initiated eventa resulting in death) LAST	DUE TO (OR AS	A CONSEQUENCE OF	F):						
P H	readility in deality Exist	d								
	PART II. Other algorificant condition	a contributing to death	but not resulting i	n the under	tylna causa	aluan in D	ert i. 24e, WAS AN	ALITORAN	24b. WERE AUTOPSY FINDINGS	
e any infu	A . C (schooti		7	The cause	given in re	PERFO		AMAILABLE PRIOR TO	
ED!	1000100	, , (0,0) (2 1707		2/34	754	1 7 YES 2	NO I	COMPLETION OF CAUSE DF DEATH?	
§ 2							_ /		1 TYES 2 NO	
23 s	DID TOBACCO USE CONTI	RIBUTE TO CAUSE C				ERTAIN				
Item Sicci	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLACE OF DEAT	H (Check only	gne)					
d, or Item	1 D YES 2 NO	1 Inpetient 2 ER/Out	patient 3 🗆 DOA		Home 5 🗆 Re	nsidence 6	Other (Specify)			
P. P.	27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	26b, TIM	E OF 280 URY	INJURY AT	2	8d. DESCRIBE HOW I	NJURY OCC	URED	
¥ >	1 Netural 5 Pending 2 Accident Investigation	, , , , , , , , , , , , , , , , , , , ,	1,000		YES 2	□ NO				
5 G	3 Suicide 6 Could not be	26e. PLACE OF INJURY building, etc. (Spe	Y — At home, farm, s	treet, factory,	office	2	ef. LOCATION (Street	and Number o	or Rural Route Number,	
82 世	4 Homicide determined	bending, etc. (Spe	спу,			1	City or Town, State)			
Item 7. E.	290. CERTIFIER	CIAN: To the heat of our burn								
= 5		CIAN: To the best of my know								
COM			on and/or investigation	n, in my opini	on, death occur	red at the lin	ne, date and placa, en	d dua to the	cause(e) end menner ee stated.	
D BE CO	296. SIGNATURE AND TITLE OF GERTIFIER	1661		10)	29c. LICE	ENSE NUMB	ER	29d. DATE	SIGNED (Month, Day, Year)	
					D16	6428		▶ //	128171	
	30. NAME AND ADDRESS OF PERSON WHO	O COMPLETED CAUSE OF DE	EATH (ITEM 27) (Type,	Print)				/		
	Casper E. Cline, 1	III, M.D., 3	00 West N	linth	Street	, Fre	derick, M	d. 21	701	
	31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGN	NATURE O							
	NOV 2 9 199	10	wen tarta	4						



DIVISION OF VITAL RECORDS, P.O.	0
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TO BE COMP	TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION
examiner must be notified at once.	IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
ve funeral director, page 5 should be detached al.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the 1 be filed within 72 hours after death with the State Dept. of Health and Mental Hyglene prior to burfal, cremation, or removal.
r death. Page 6 may be retained by the hospi	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospi

STATE OF	MARYLAND /	DEPARTMENT	0F	HEALTH	AND	MENTAL	HYGIENE
	CE	ERTIFICATE	0	F DEAT	TH		REG. NO.

	FOR 1 - STATE REGISTRAR	STATE OF MARYL		ENT OF HEALTH A		L HYGIENE REG. NO.				
	t. DECEDENT'S NAME (First, Middle, Last)				2. DATE	OF DEATH	YE	3. TIME OF DEATH		
	Webster L	Simmons	•		ember [™] l		95 4:00 рм			
	4.5978L SECURITY 2/2/5ER	5. SEX 8. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 77 YRS. MONTHS DAYS HOURS MIN. July 27, 19						State or Foreign (State or Foreign ashington, DC		
_	9e. FACILITY NAME (If not institution, give			CITY, TOWN OR LOCATION			9c. COUNTY	OF DEATH		
DIRECTOR	Washington Advent	ist Hospital	T	akoma Park,	MD	1	Montgo	mery		
EC	10e. STATE 10b. COUNT	ΓY		OWN OR LOCATION				tod. INSIDE CITY LIMITS?		
		ce Georges	Adel					t 🕅 YES 2 🗌 NO		
FUNERAL	100. STREET AND NUMBER 8037 New Riggs R	d		10f. ZIP CODE 2078	3		USA	OF WHAT COUNTRY?		
E.	11. MARITAL STATUS 1 Never Merried 2 Merried	12. WAS DECEDENT EVER 1 FORCES? 1 YES	2 🖵 NO	13. WAS DECENDENT OF If yes, specify Cuban,	Mexicen, Puerto			RACE — American Indian, Black, White, etc.		
BY	3 Widowed 4 Divorced	IF YES, GIVE WAR OR D	ATES 21	t ☐ YES 2 ZŽ-NO	Specify:			Specify: Black		
COMPLETED	t5. DECEDENT'S ED	UCATION le completed)	18e. DECEDENT'S USI	done during most of working	16t	. KIND OF BUSIN	ESS/INOUST			
7	Elementary/Secondary (0-12)	College (1-4 or 5+)	ille. Do NOT use re							
OME	5th 17. FATHER'S NAME (First, Middle, Last)	<u>-</u>	Custodia		R'S NAME (First,	Jalter I Middle, Malden Su	Reed A	rmy Hospital		
ш	George Simmons			Mar	ie_Simm	one				
TO B	19e. INFORMANT'S NAME (Type/Print)		19b. MAILINO AD	DRESS (Street end Number or			State, Zip Cod	lo)		
F	Dorothy Powell-		3303 Ma	yo Place, 5						
	20e. METHOD OF DISPOSITION M Burlel 2 Cremetion 3 Res	movel from State COT	metery, crematory or other	ISPOSITION (Name of plece)	DAT			or Town, State		
	4 Donetion 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE L	ICENSEE Ma	ryland Nat	ional Cemet	ery 11/	22 Laur Home	rel. M	D		
	Dom.	andall		4217 9th S	treet N	I. W.				
\dashv	23. PART I Enter the diseases, Dr	complications that couse	d the death. Do not	LWashington enter the mode of dying	, auch ea car	diac or reapira	tory arreat,	Approximate		
	ahock, or haert fellure iMMEDIATE CAUSE (Final	. List only one cause on e		. 2.6				Interval Between Onset and Death		
	disease or condition resulting in death)			IPCE	W,	Y F C	OWI	1		
	DUE TO (OR AS A CONSCIUENCE OF):									
ON	Sequentially list conditions, Due to (or as a consequence of):									
CAT	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury									
CERTIFICATION	that initiated events resulting in death) LAST	t initiated events DUE TO (OR AS A CONSCOUENCE OF):								
GE		d								
AL	PART II. Other significant condition			ha underlying cause giv	van In Part I.	24s. WAS AN AI PERFORM		24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO		
MEDICAL	FLYDEISGENSION 1 VES 250 NO							DF DEATH?		
	DID TOBACCO USE CON	TRIBLITE TO CALISE O	DE DEATH YES		RTAIN			1 YES 2 NO		
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL		28. PLACE OF DEATH		KIAII L					
SIC	t VES 2 NO	HOSPITAL:		THER: Nursing Home 5 Reel	dence 8 🗆 Oth	er (Specify)				
PH	27. MANNER OF DEATH	28e. DATE OF INJURY (Month, Day, Year)	28b. TIME C	Y WORK?		SCRIBE HOW IN.	JURY OCCUR	ED		
В	Natural 5 Pending 2 Accident Investigation		× 11 hard to 100	M 1 YES 2		C471041 /C	d Shambar as d	New Courts Manufacture		
E I	3 Suicide 8 Could not be 4 Homicide determined	3 Suicide 8 Could not be determined 28e. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify) 28t. LOCATION (Street and Number or Rural Route Number, City or Town, State)								
COMPLET	CONBOR ONLY 5 -	SICIAN: To the best of my know						waste and manner as eterad		
	one) 2 MEDICAL EXAMINER: On the beele of exemination end/or investigation, in my opinion, death occured at the time, date									
0.0	20h SIGNATURE AND TITLE OF CENTUR	29c. LICENSE NUMBER 20d. DATE SIGNED (Month, Day, Yea								
BE	29b. SIGNATURE AND TITLE OF CERTIFIC	AC.		101	997		111	GNED (Month, Day, Year)		
TO BE	30. NAME AND ADDRESS OF PERSON W	do	EATH (ITEM 27) (Typo, Pr	0 1	997	230,	TAK	GNED (Month, Day, Your) 17 95 20912		

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DIVISION OF VITAL RECORDS, P.O. BOX 68760	Mr The law requires that the death carti
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TO THE HOSPITAL OR ATTENDING PHYSICIAN; The law requires that the death certificate be executed within 24 hours after death. Page 6 may he retained by the honorisal or artendang observation	AL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or remonal.	MPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	
THE HOSPITAL OR ATTENDIN	THE FUNERAL DIRECTOR; After this control filed within 72 hours after death with	MPORTANT: If item 28 is r	

	1 - FOR STATE REGISTRAR	STATE OF MARYLAND			OF HEALTH AND	MENTA	AL HYGIENE					
	1. DECEDENT'S NAME (First, Middle, Last) RICHA				4021	NOV	E OF DEATH DAY		YEAR	9.100 A M		
	4. SOCIAL SECURITY NUMBER 579-52-6340	5. SEX 8. AGE (In yrs. In	st birthday)	MONTHS	DAYS HOURS MIN.		23740	, W	BIRTHP	ington, DC		
OR	90. FACILITY NAME (If not institution, give st Southern Maryl				TOWN OR LOCATION OF linton	DEATH		9c. COUNT	Y OF DE	ATH		
ECI	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY		10c. CIT	Y TOWN O	R LOCATION				=	10d, INSIDE CITY		
DIRECTOR	MD	PG			le Hills			LIMITS?				
ERAI	100. STREET AND NUMBER 3334 27th Ave	nue			20748			10g. CITIZEN OF WHAT COURS				
BY FUNERAL	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN U.S. AF FORCES? 1 YES 2 IF YES, OIVE WAR OR DATES	NO	11	MS DECENDENT OF HISP yes, specify Cuban, Maxi YES 2 NO Specific	can, Puerto	IN? (Specify Yes of Rican, etc.)	or No—	Black,	- American Indian, White, etc. Black		
COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed) 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 17. Yrs 18b. KIND OF BUSINESS/INDUSTRY Governmental Fireman (DC Fire Department)											
BE CON	17. FATHER'S NAME (First, Middle, Last) Everett W. Stevenson, Sr. 18. MOTHER'S NAME (First, Middle, Maiden Surneme) Mary A. Ford											
5	19a. INFORMANT'S NAME (Type/Print) Mary A. Steverson 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3309 27th Avenue, Temple Hills, Md., 20748											
	20s. METHOD OF DISPOSITION 20											
	21. SIGNATURE OF FUNERAL SERVICE LICE		+=	22. N								
9	21. SIGNATURE OF FUNERAL SERVICE LICENSEE Polest L. Signature of Funeral Service Licensee 22. NAME AND ADDRESS OF FACILITY To Rhines Co., Inc. 3030 12th St NE, DC 20017 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate											
CERTIFICATION	Approximate shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events) Due to (or as a consequence of):											
	that initiated events resulting in death) LAST PART II. Other significent conditions				lashina assas alsa i		I					
MEDICAL	Anemia SIPSEPS		readiting i		errying cause given i		24a. WAS AN A PERFORM 1 TYES 2	ED?		VERE AUTOPSY FINDINGS MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? YES 2 NO		
Ä	DID TOBACCO USE CONTR					IN 🗆						
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO	HOSPITAL:	CE OF DEAT	OTHER								
HYS	27. MANNER OF DEATH	1 Cinpetient 2 ER/Outpetient 3	28b. TIM		ng Home 5 Residence	_	er (Specify) SCRIBE HOW IN.	HIPM OOD!	200			
ВУ Р	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	INJ	M	WORK?	28d. DE	SCHIBE HOW IN	JURY OCCUI	RED			
	3 Suicide 6 Could not be 4 Homicide determined	28e. PLACE OF INJURY — At he building, atc. (Specify)	ome, ferm, e	treet, facto	ry, office	offica 281. LOCATION (Street and Nui City or Town, State)			ber or Rural Route Number,			
COMPLETED		CIAN: To the best of my knowledge, de R: On the besis of examination and/or								and manner as stated.		
8	296. SIONATUME AND TITLE OF CERTIFIER 296. LICENSE NUMBER 296. DATE SIONEO (Month, Day, Year) D46478 1-20-95											
5	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Typo, Print) 7501 SURRATTS RD-SUITE 302, CLINITON MD 2073+											
	31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE											
	NOV 27 1995 Jul	in Davidson Randall										

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BALLIMONE, MANTLAND 21213-0020	24 hours after death. Page 6 may be retained by the hospital or attending physician.	THE FUNERAL OHECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunal-transit permit. Pages 1, 2, 3 should lied within 72 hours after death with the State Dept. of Health and Mental Migliene prior to bunal, cremation, or removal.	the medical examiner must be notified at once.	
	TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	

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	1 - STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MERCHAND OF DEATH	MENTAL HYGIENE REG. NO.			
1000	1. DECEDENT'S NAME (First, Middle, Lust) YOLQNGO Saleon	2. DATE OF DEATH DAY A DAY A DAY	70-98 6554		
The state of	4. SOCIAL SECURITY NUMBER 5. SEX 1 M 2 KF 9e. FACILITY NAME (if not institution, give street and number) 9. CITY, TOWN OR LOCATION OF DE	7. DATE OF BIRTH (Month, Day, Year)	B. BIRTHPLACE (State or Foreign Country)		
TOR	Hyattsville,		rince Georges		
DIRECTOR	106. STATE ND 106. COUNTY PG GOOD TO THE CATION OF LECATION		10d. INSIDE CITY LIMITS? t YES 2 NO		
COMPLETED BY FUNERAL	3402 37th Place 101, ZIP CODE 20122-	2000 log.	CITIZEN OF WHAT COUNTRY?		
	t1. MARITAL STATUS t Never Married 2 Married 12. WAS DECEDENT EVER IN U.S. ARMEO FORCES? 1 YES 2 NO If yes, specify Cuben, Maxicar 1 YES, GIVE WAR OR DATES 13. WAS DECEDENT OF HISPAN If yes, specify Cuben, Maxicar 1 YES 2 NO Specify.	n, Puerto Rican, etc.)	14. RACE — American Indian, Black, White, etc. Specify: Black		
	ts. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5 +) 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)	18b. KIND OF BUSINESS Medical			
	17. FATHER'S NAME (First, Middle, Lest) 18. MOTHER'S NAM	ME /First Middle Maides Suman			
TO BE	196. INFORMANT'S NAME (Type/Print) Pearl Howard 196. MAILING ADDRESS (Street and Number or Rural R 3402 37th Place Colm.	loute Number, City or Town, State,			
	20s. PETHOD OF DISPOSITION 1 Burlei 2 Cremetion 3 Ramoval from State 4 Donation 5 Other (Specify)	DATE 20c. LOCATION	I — City or Town, Stata		
	21. SIGNATURE OF TUNERAL, BERVICE LICENSEE 22. NAME AND ADDRESS OF FICE ALEXANDER S.	Pope Funeral e SE Washingt	Homes		
	23. PART I. Enter the disesses, or complications that caused the daeth. Do not anter the mode of dying, such shock, or heart fallure. List only one cause on each line. IMMEDIATE CAUSE (Final disesse or condition resulting in dasth)	New Fysill	Srrest, Approximate interval Batween Onset and Dastr		
CERTIFICATION	Sequentisity list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury thet initiated events resulting in death) LAST				
MEDICAL	PART, II. Other significant conditions contributing to death but not resulting in the underlying cause given in a	T PERFORMED?	24b. WERE AUTOPEY FINDINGS MALLAGE PRIOR TO COMPLETION OF GAUSE OF SEATH? 1 YES 2 NO		
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 1 postlent 2 ENOutpatient 1 DOA Officer Home 5 Residence (6 [] Other (Specify)			
ВУ РН	27. MANNER OF DEATH 1 Superior 5 Pending 2 Accident Investigation 28s. DATE OF INJURY N/A N 29s. TIME OF NUMBER AT WORK? 1 YES 2 X NO	264. DESCRIBE HOW INJURY OCCURED N/A			
60	3 Suicide 6 Could not be determined 28e. PLACE OF SAURY — At home, farm, street, factory, office building, etc. (Specify) N/A	28f, LOCATION (Steel and Num City or Xwen, State)	ther or Plurel Ploute Mumber. /A		
BE COMPLET	296. CERTIBLER Check body 2 MEDICAL-EXAMINER: On the basis of symmostic and/or investigation, in my opinion, death occurred at the 1 29th \$100ATURE AND TITLE OF CESTIFER 29th \$100ATURE AND TITLE OF CESTIFER 29th \$100ATURE	time, date and place, and due to			

29d. DATE SIGNED (Month, Day.

31. DATE FILEO (Month, Day, Year) 1995 NOV



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REGIS	TRAR				ERTIF	ICATE (OF D	EATH		REG. NO.				
1. DECEDEN	T'S NAME (First,	Middle, Last)								OF DEATH			TIME OF DEATH	
BAI	RRY	JAM	JRICE	SHARE)				NOV	EMBER		1995	03:30A M	
	98-161		5. SEX 1 🔀 M 2 🗌 F	6. AGE (In yrs. 31	lest birthday) YRS,	IF UNDER 1 Y		UNDER 24 HRS.	7. DATE (Month	OF BIRTH n, Day, Year)	64	8. BIRTHPLI Country)	ACE (State or Foreign	
9e. FACILITY	Y NAME (If not in	stitution, give st	reet and number)					OCATION OF C	EATH		Н			
110	0 BLK		HVIEW D	RIVE	Oxon Hill, Maryland						PRINCE GEORGES			
110 RESIDEN 100. STATE Maryl	and	Prin	ce George	es	Temple Hills, Maryland						10d. INSIDE CITY LIMITS? 1 TYPES 2 NO			
	AND NUMBER	Avenue						20748				ted St	tates	
11. MARITAL 1 X Never I	STATUS Merried 2 Divo		12. WAS DECEDENT FORCES? 1 IF YES, GIVE W		ARMED NO	RMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No— If yes, specify Cuben, Maxican, Puarto Rican, etc.) 1 □ YES 2 NO Specify: Specify								
	15. DEC	EDENT'S EDU	CATION	16a.	DECEDENT'S	USUAL OCCI	JPATION		16b	KIND OF BUS	SINESS/IND	DUSTRY		
	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)				(Give kind of v life. Do NOT us Cons	se retired.)		working Worker		Priv	ate/	Const	ruction	
	s NAME (First, M		Sharp				18	Ann W			Surname)			
	MANT'S NAME (7				195 MAII INO	ADDRESS /S	Street and A	Number or Rure	I Boute Num	her City or Tow	n State 7in	Codel		
	Sharp	ypa: inky						ue Tem						
20a METHO 1 Burial	D OF DISPOSIT	ION In 3 Am	ovel from State		CE AND DATE (ther place!			DAT		CATION —	City or Town	, State	
4 🗆 Donatk	Ion 🐧 🗆 Other	(Specify)				Res		ection		25 (Clint	on, M	aryland	
21. SIGNATU	CVO N	/ SERVICE AIC	Van	o K		Ale	exan	der S.	Pope				2000	
DA PART	1301		complications that	7,	death De s			enn Av					Approximate	
IMMEDIAT	shock, or h TE CAUSE (Fire condition	eert fellure.	s. Due to			_		tu					Interval Between Onset and Daeth	
Sequentially list conditions, If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):														
Sequentis If any, les Cause. En CAUSE (D that initial resulting i			d.										1	
	Other algnifica	ent condition	es contributing to	daath but no	ot reaulting	In the Unde	erlying c	auae given i	n Part I.	24a, WAS AN PERFOR	RMED?	A	ERE AUTOPSY FINDINGS MILABLE PRIOR TO OMPLETION OF CAUSE F DEATH? YES 2 \(\subseteq \text{NO} \)	
DID TO 25. WAS CAS EXAMIN 1 VE 27. MANNER	OBACCO U	SE CONT	RIBUTE TO CA	USE OF DI	EATH YE	ES NO	ON	UNCERTA	IN 🗆			1		
25. WAS CAS	SE REFERRED 1	O MEDICAL		26. PI	LACE OF DEA	TH (Check onl	ly dhe)							
1 X YE	S 2 NO		HOSPITAL:	ER/Outpatient	3 🗆 DOA	OTHER:	g Home	5 - Rasidence	6 XOthe	er (Specify)	SCEN	ΙE		
27. MANNER			28st. DATE OF	INCOURTY INCOURTY	26b. TIN	IE OF 2	Bc. INJURY WORK		28d. 05	CRIBE HOW			d-	
1 Nat	_	Pending Investigation	11/19	195	0/3	7 "	1 YES	2 NO	0	Obje	cy	She	$\sqrt{}$	
3 Sul-	0 []	Could not be determined	28e. RLACE d building,	F INJURY — Al atc. (Specify)	STP	etreet, tactor	y, office	/ \	City	OF TOWN State	Soul	7 or Rural Rou 12-Vie	D Ave	
29a. CERTIF	FIER 1 CER	TIFYING PHYS	ICIAN: To the best of	my knowledge	death occurr	red at the tim	e, date en	d place, and di	ue to the ce	use(e) and me	nner se sia	ited.		
1000	~												nd menner as stated.	
2 SIGH	URE AND TITLE	OF CERTIFIE	oshe	mD			-	9c. LICENSE N				TE SIGNED (A	forth, Day, Year) R 19 199!	
30. NAME A	A PON		HO COMPLETED CAU	1	111 F		Stre	eet,	Balt	imore	, Ma	ryla	nd 21201	
31. DATE FIL	LED (Month, Day,	7 199	32. RIPGISTRI	IR'S SIGNATUR	Radal									

Man America of

3. TIME OF DEATN

12:58

Approximate Interval Batween Onset and Death

4 hours

24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH?

BIRTNPLACE (State or Foreign Country)
 Mary land

REG. NO.

2. DATE OF DEATH DAY NOVEMBER

FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

MARTHA

4. SOCIAL SECURITY NUMBER

'		4. SOCIAL SECURITY NUMBER 202-09-5006		5. SEX	6. AGE (In yrs. le	st birthday)	IF UNDER	DAYS	IF UNDER	24 HRS. MIN.	7. DATE C	29,19	211	8. BIRTNI	PLACE (State or Foreign y) yland
pino		9a. FACILITY NAME (If not in	_		04	Tho.	ah CITY	/ TOWAN O	R LOCATIO	ON OF DE		29, L		NTY OF DE	-
3 should	R	Prince Geor			Center			Cheve		on or be	.Alte				ETRGE'S
3 1, 2	5	RESIDENCE OF DEC	CEDENT												
physician. burial-transit permit, Pages 1, 2,	DIRECTOR	Maryland		e George	s	Mitchellville								10d. INSIDE CITY LIMITS? t YES 2 NO	
n. Insit pera	FUNERAL	100. STREET AND NUMBER		Road A	pt. 1109	1	101. ZIP CODE 20721							J.S.A	HAT COUNTRY?
	BY FUN	11. MARITAL STATUS 1 Never Merried 2 X 3 Widowed 4 Divo	Merried	12. WAS DECEDED FORCES?	NT EVER IN U.S. A 1 YES 2 X WAR OR DATES	MO If yes, specify Cuben, Mexican, Puerto Ricen, etc.)							Black	— American Indian, White, atc.	
r attenduse as	COMPLETED		CEDENT'S EDU ly highest grade 0-12)		(0	16e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working ##e. Do NOT use retired.)									
be detached for at once.	OMP	17. FATNER'S NAME (First, A	Aiddle, Last)	1	De	Dental Hygienist Dental Office 16. MOTNER'S NAME (First, Middle, Meiden Surneme)								fice	
	BE C	J.E.T. Be							Ma	arth	a Vic	toria	She		
be retained ge 5 should e notified	5	190. INFORMANT'S NAME (Type/Print) 190. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Walter G. Shaffer 10450 Lottsford Rd.#1109, Mitchellville, M												,Md.20721	
leath, Page 6 may be funeral director, page xaminer must be		Walter G. Shaffer 20e. METHOD OF DISPOSITION 1 Burdel 2A Cremetton 3 Removal from State 4 Donation 5 Donation 5 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of Late of Date												wn, State Virginia	
death, Page funeral direct L examiner n		21. SIGNATURE OF FUNERA	and in contrast of the last	angles 1	Heti	Opol	22.	NAME AN	ND ADDRES	SS OF FA	CILITY	unera:			VIIGINIA
0 = 0		Horg	601	ale	V			6160	0xor	n Hi	11 Rd	. 0xo	n Hil	11, M	4d.20745
24 hours at filled in by ion, or rem the medic		23. PART I. Enter the debt ahoof, or h IMMEDIATE CAUSE (Fit disease or condition resulting in desth)	neart failure. nai	ENCL-S	use on each lin	s.						. /		rest,	Approximata Interval Batwe Onset and Date 4 Hours
and con o burial, natic e	NOI	Sequentisily list condi	tions,		COLEMIA O OR AS A CONS		,								UNK
certificati ding phy Hygiene p	CERTIFICATION	cause. Enter UNDERLYING CAUSE (Disease or Injury that Initiated events resulting in death) LAST											UNK		
at the d by the and Me y injur		PART II. Other signification										24a. WAS AN PERFOR	MED?	24b.	WERE AUTOPSY FINDING AMAILABLE PRIOR TO COMPLETION OF CAUSE
sign Heal	PHYSICIAN: MEDICAL	"Edoma,	akemi	2		1					_	1 YES 2	ANO		OF DEATH?
law las t	AN	DID TOBACCO U		RIBUTE TO CA		CE OF DE				ERTAI	иП				
ate ate	rsici	EXAMINER?		HOSPITAL:	ER/Outpatient		OTHE	R:		aldence	6 🗆 Other	(Specify)			
this with			Pending Investigation	26a. DATE O (Month,	F INJURY Day, Year)	26b. TII	ME OF JURY M		URY AT ORK? YES 2	NO	28d. DE\$	CRIBE HOW I	NJURY OC	CURED	
OR ATTENDING PHYSICIAN: DIRECTOR: After this certifical hours after death with the St item 28 is marked, or if	ED BY	2	Could not be datarminad		OF INJURY — At h	ome, ferm,	street, fac	ctory, offic				ATION (Street of Town, State)		or or Runal F	loute Number,
DIRE	COMPLETED		TIFYING PHYS	ICIAN: To the best of	of my knowledge, d	leath occur	red at the	time, data	and place	, and due	to the cau	se(s) and mer	nner as atı	sted.	····
		29b. SIGNATURE AND TITL			exemination and/o	Investigat	on, In my	opinion, d	_	red at the		and place, an			e) and manner as stated
TO THE HOSPI TO THE FUNER be filed within	TO BE	Absenged	- IND							59:					cr 24, 1995
10		J. BERGER		#205,	7720 W	18con	o, Print)	Ave	, Be	Nes	da,	ind :	7007	4	
		31. DATE FILED (Month, Day, NOV 2	7 1995	32. BEGISTE	AR'S SIGNATURE	and the									

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE **CERTIFICATE OF DEATH**

SHAFFER

DHMH-16 Rev 1/89

A STATE OF THE STATE OF THE

ITEMS: 23 PART I, 27, PER MEO FILM G-730 12/20/95 t.t

38010 95

	1 - STATE REGISTRAR	STATE OF MA				HEALTH AND	MENTA	L HYGIENI	E	, ,		
	1. DECEDENT'S NAME (First, Middle, Last)							OF DEATH		3.	. TIME OF DEATH	
	DESTINY			S	CHNEI	DER	NOV		10.1	G Q S	0635 AM	
18	4. SOCIAL SECURITY NUMBER		8. AGE (In yrs. las	st birthday)	IF UNDER 1 YEA	-	7. DATE	OF BIRTH h, Day, Year)	8.		ACE (State or Foreign	
	214-45-4720	1 🗌 M 2 💢 F	X F YRS. 3 24						1995		land	
	9a. FACILITY NAME (If not institution, give s	treet and number)				N OR LOCATION OF D	EATH		9c. COUNTY	-		
5	ANNE ARUNDEL M	EDICAL (CENTER		ANNA	POLIS		UNDEL				
וני	10a. STATE 10b. COUNTY	1		10c. CITY	, TOWN OR LO	CATION				16	Dd. INSIDE CITY	
DIRECTOR	Maryland Anne	Arundel		Lot	hian				LIMITS?			
4	10e. STREET AND NUMBER					101. ZIP CODE			tog. CITIZES	N OF WHA	AT COUNTRY?	
	90 B Berts Drive					20711			Unit	ed S	tates	
FUNER	11. MARITAL STATUS 1 Never Married 2 Merried	12. WAS DECEDENT FORCES? 1	EVER IN U.S. AF	RMED NO		SPECENDENT OF HISPA specify Cuban, Maxica			or No- 14	RACE -	- American Indian, White, atc.	
Ā	3 Widowed 4 Divorced	IF YES, GIVE WA			1 0	ES 2 NO Specif	fy:	,		Specify:	White	
3	15. DECEDENT'S EDU	CATION	18a. DE	CEDENT'S	USUAL OCCUP	ATION	168	. KIND OF BUS	INESS/INDUS	TRY	wnite	
	(Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4 or 5+)	(G		rork done during	most of working						
COMPLE	0			/A				N/A				
5	17. FATHER'S NAME (First, Middle, Last)					18. MOTHER'S NA	AME (First,	Middle, Maiden	Surname)			
H H	William Schneider					Gail S	chnei	lder				
5	19a. INFORMANT'S NAME (Type/Print)					et and Number or Rural				ode)		
-	William Schneider					rive, Lot	hian,			2071		
	20s. METHOD OF DISPOSITION 1 X Burlet 2 Cremetion 3 Rem	oval trom Stats	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Fort Lincoln Cemetery 11/13/95 Brentwood, Ma							111111111111111111111111111111111111111		
	4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LIG	CENSEE	Fort	Linco				95 Bre	ntwood	1, Ma	aryland	
b	22. NAME AND ADDRESS OF FACILITY Fort Lincoln Funeral Home, Inc. 3401 Bladensburg Rd., Brentwood, MD 20722											
	(XUA)	1. 10	KNA	UK							MD 20722	
	23. PART i. Enter the disesses, or ahock, or heert feliure.	complications that List only one cous	caused the di se on each line	eath. Do n	ot enter the	mods of dying, suc	ch aa can	diac or respi	ratory srres	t,	Approximata intervsi Between	
	IMMEDIATE CAUSE (Fine) diseese or condition BRONCHO PNEUMONIA											
	diseese or condition a. BRONCHO PNEUMONIA OUE TO (OR AS A CONSEQUENCE OF):											
,				.002.102 01	7-							
5	Sequentially list conditions, If any, leading to immediate	DUE TO (OR AS A CONSE	OUENCE OF	7):							
3	cause. Enter UNDERLYING CAUSE (Disease or Injury	C										
RIFICATION	that initiated evente resulting in death) LAST	DUE TO (OR AS A CONSE	DUENCE OF	7):							
	Testiting in destil) Exist	d										
- 1	PART II. Other significant condition	na contributing to	death but not	reculting i	n the underl	ying cause given in	Part I.	24s. WAS AN			ERE AUTOPSY FINDINGS	
2								PERFOR		C	MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?	
MEDIC											YES 2 NO	
	DID TOBACCO USE CONT	RIBUTE TO CAL	JSE OF DEA	ATH YE	S NO	☑ UNCERTAI	IN 🗆					
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	28. PLA	CE OF DEAT	OTHER:	ne)						
2	1 X YES 2 NO	1 Inpatient 2 💢		-	4 - Nursing I	tome 5 - Residence	1					
	27. MANNER OF DEATH 1 Netural 5 Pending	28a. DATE OF I (Month, Da		28b. TIM INJ	URY	INJURY AT WORK?	28d. DE	SCRIBE HOW I	NJURY OCCU	RED		
B	2 Accident Investigation	28a PLACE OF	INJURY — At h	ome term o		YES 2 NO	200 1 00	CATION (Street a	and Mumber or	Dural Day	de Muselan	
3	3 Suicida 8 Could not be 4 Homicide determined	building, e	nc. (Specify)	oma, um, a	nriiet, tectory, t	HIIGO		or Town, State)	ina Number or	HURBI MOU	Te Number,	
COMPLEIE	29a. CERTIFIER											
3	(Check only one) 1 CERTIFYING PHYS 2 MEDICAL EXAMINE											
3			- Introduction English	investigano	ii, iii iiiy opiiiio			and place, an				
N N	AND TITLE OF CERTIFIE	"Uh 10.				29c. LICENSE NU					Month, Day, Year)	
2	30. NAME AND ADDRESS OF PERSON WE	10 COMPLETED CAUS	E OF DEATH (ITE	M 27) (Type	Print)	O.C.M.	NOVEMBER 10,199				EK 10,1990	
	1 1 0	RELL MO				et, Balt	imo	re. Ma	arvla	nd	21201	
	31. DATE FILED (Month, Day, Year)	32. HUBISTHAF	S SICHATURE		DOLO	, bare		,	-1			
	NOV 2 9 199	5 July	A STANSON	WARA!								

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YSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	is certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunat-transit permit. Pages 1, 2, 3 should with the State Dept. of Health and Mental Hygiene prior to burfal, cremation, or removal.	d, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate to	▼ TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burfal, cremation, or removal.	IMPORTANT: if item 28 is marked, or item 23 shows any injury, or other tra

	1 - FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPART			MENTAL HYGIEN							
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH			3. TIME OF DEATH				
	Marie Madeline S	cherer				November	26. 1	995	3:30 p M				
		The second secon		IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)			IPLACE (State or Foreign				
	273 21 03 13	□ M 2 🖾 F 75	YRS.	ONTHS DAYS	HOURS MIN.	Feb. 7, 1	920	Pennsylvania					
~	9a. FACILITY NAME (If not institution, give stree	t and number)	1 1	9b. CITY, TOWN	OR LOCATION OF E	DEATH	9c. COU	NTY OF D	EATH				
0	5004 36th Place			Hyatt	sville		Pri	nce	George's				
EC	10e. STATE 10b. COUNTY		10c. CITY,	TOWN OR LOCA	TION				10d. INSIDE CITY				
DIRECTOR	Maryland Prince	George's	Hva	attsvil	16			LIMITS?					
	10a. STREET AND NUMBER		/-		f. ZIP CODE		10g. CIT	IZEN OF V	VHAT COUNTRY?				
FUNERAL	5004 36th Place				20782		U.S	. Δ	N - 1104 - 1104 - 1104 - 1104 - 1104 - 1104 - 1104 - 1104 - 1104 - 1104 - 1104 - 1104 - 1104 - 1104 - 1104 - 1				
5		2. WAS DECEDENT EVER IN		13. WAS DE	ENDENT OF HISPA	NIC ORIGIN? (Specify Ye		14. RACI	- American Indian,				
BY	1 Never Married 2 Married 3 Widowed 4 Divorced	FORCES? 1 TYES			ecify Cuban, Maxic 2 🔯 NO Speci	en, Puerto Ricen, etc.)		Speci	t, White, etc.				
	15. DECEDENT'S EDUCAT	Tour I			-				White				
COMPLETED	(Specify only highest grade cor	mpleted)	(Give kind of wo life. Do NOT use	rk done during m	ON ost of working	16b. KIND OF BL							
2	Elementary/Secondary (0-12)	College (1-4 or 5+)	Insuranc	,	ina	Prince General							
<u>▼</u>	17. FATHER'S NAME (First, Middle, Last)		Institution	C DIII		AME (First, Middle, Maider		ıtaı					
ш	Isidore Francis Ke	ller			Sarah		· Garrianney						
0 8	19a, INFORMANT'S NAME (Type/Print)		19b. MAILIND A	DORESS (Street		Route Number, City or Tox	vn, State, Zip	Code)					
ř	Jane M. Brown		5004 36	th Pla	ce, Hyat	tsville, M	aryla	nd	20782				
	20a. METHOD OF DISPOSITION 1 ☐ Buriel 2 ☒ Cremetion 3 ☐ Remova	from State 20b.	PLACE AND DATE OF	DISPOSITION (N	ame of	DATE 20c, LC	wn, State						
	Cameton S Removal from State Cameton Cameton												
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE Landes F. Bell L Francis Gasch's Sons Funeral Home, P												
	23. PART I. Enter the diseases, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest. Approximate												
ICAL CERTIFICATION	ahock, or heart failure. Lie IMMEDIATE CAUSE (Final disease or condition reaulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART. II. Other aignificant conditions of	DUE TO (OR AS A DUE TO (OR AS A Ontributing to death bu	CONSEQUENCE OF):	the underlyin		PERFO	RMED?	24b.	Interval Between Onset and Daath WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE				
MEDIC		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	(1		1 TYES :	2 MO	-	OF DEATH? 1 YES 2 NO				
PHTSICIAN:	DID TOBACCO USE CONTRIB 25. WAS CASE REFERRED TO MEDICAL		F DEATH YES	Check only one	UNCERTAI	N		\perp					
2	EXAMINENT?	OSPITAL:		THER:		AUI _ 15 a56							
Ě	27. MANNER OF DEATH	28s. DATE OF INJURY	28b, TIME		e 5 PResidence	8 Other (Specify) 28d. DESCRIBE HDW	IN ILIEN OCC	LIBED					
- 1	1 Natural 5 Pending	(Month, Day, Year)	INJUI	ly Wo	RK? YES 2 ND	and begoning right	INJUNI OCC	JUNEO					
ED 8	3 Suicide 8 Could not be	28s. PLACE OF INJURY building, etc. (Special	— At home, ferm, etr	est, factory, offic	•	281. LOCATION (Street City or Town, State,	and Number	or Rural R	oute Number,				
- 1	4 Homicide determined					ony or rown, orang							
OMPLE	29e. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAL ONE) 2 MEDICAL EXAMINER: D	N: To the best of my knowled on the basis of examination	edge, death occurred and/or investigation,	at the time, dete in my opinion, o	and place, and due	to the cause(s) and ma	nner es state	ed. e cause(s	and manner as stated.				
	296. SIGNATURE AND TITLE OF CENTIFIER) . ^			29c. LICENSE NU	MBER	29d) DATE	SIGNED	(Month, Day, Year)				
	(Mugusto). To	diffugy	W	1	4212	30	127,1995						
	And I was P. P.	Janes MIK	TH (ITEM 27) (Type, P)	Lay Dr	um Ch C	0 5m. 7	Ed o	207	48				
31. DATE FILED (Month, Day Year) 32. ABOUSTRAR'S SIGNATURE.													

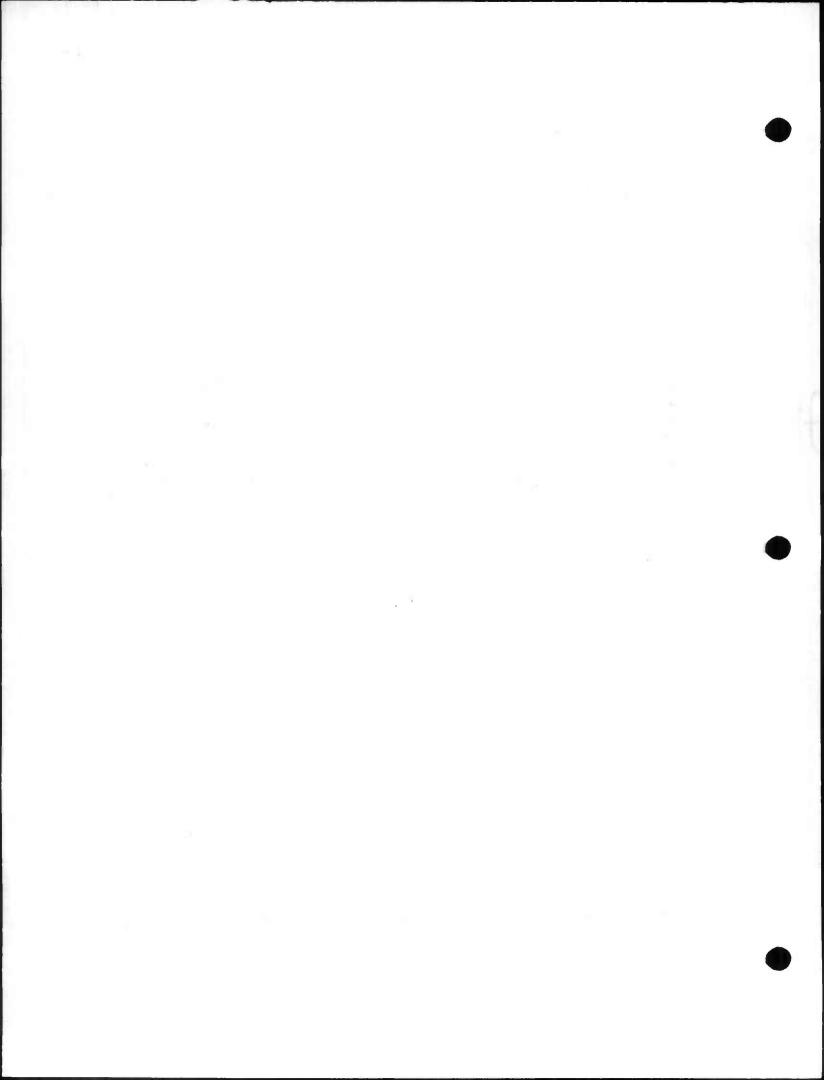
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	1 - STATE REGISTRAR	STATE OF I	MARYLAND /		ICATE				ENTAL	HYGIENI REG. NO.	E			
	1. DECEDENT'S NAME (First, Middle, Last)		- OL		IOAIL	01	DEATH			OF DEATH			3. TIME OF OEATH	
	Nellie	Mav				S	helor	D	монтн Эесепі	ber 2		995	4:45 A	м
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. last	birthday)	IF UNDER 1	YEAR	IF UNDER 24	HRS. 7	DATE O	F BIRTH Day, Year)			LACE (State or Foreign	_
	213-16-4951	1 🔀 M 2 🗌 F	91	YRS.	MONTHS	DAYS	HOURS	WIN.	SEPT	.29,1	904		ORF, MD	
_	9s. FACILITY NAME (If not institution, give st						LOCATION	OF DEAT			9c. COU	NTY OF DE		
6	Physicians Memorial	Hospital			LaPlata, Maryland					Charles				
<u>D</u>	RESIDENCE OF DECEDENT 10s. STATE 10b. COUNTY	,		10c. CIT	Y, TOWN OR	LOCATIO	ON		10d, INSIDI					\exists
DIRECTOR	MARYLAND CH	ARLES			WALD	ORF							LIMITS?	
	10e. STREET AND NUMBER					10f.	ZIP CODE			-	10g. CIT		HAT COUNTRY?	\neg
E	P.O. BOX 303						20604	4				U.S.A	S.A.	
FUNERAL	11. MARITAL STATUS	12. WAS DECEDED FORCES?	MED 13. WAS OECENE 10 If yes, specific											
ВУ	1 Never Married 2 Merried 3 N Widowed 4 Divorced	WAR OR DATES				2 X NO			out, and,		Specifi	y.		
	15. DECEDENT'S EDUC	16a, DE	CEDENT'S	USUAL OCC	LIPATIO	4		16h	KIND OF BUS	INFRC/INI		HITE	-	
E	(Specify only highest grade Elementary/Secondary (0-12)	(Gi	ve kind of	work done du se retired.)				100.	ALIVO OF BOS		0001111			
IPL	12	College (1-4 or 5		ER/O	PERAT	OR				RETAI	I ST	ORF		
COMPLETED	17. FATHER'S NAME (First, Middle, Last)			2117	Livit		18. MOTHER	R'S NAME	(First, M	iddle, Maiden		VILL		
BE C	FRANK H. KERR						IDA	M	AE	ROBI	NSON			
10	19s. INFORMANT'S NAME (Type/Print)									er, City or Town	. State, Zij	p Code)		
-	PATRICK D. SHELOR				BOX 3			RF,	MARY		206			
	20s. METHOD OF DISPOSITION 1 X Burisi 2 Cremetion 3 Remeted Donstion 5 Other Special	gyal from State	complete crematory or other place!						DATE 20c. LOCATION — City or Town, State 12/6 WALDORF, MARYLAND					
	4 ☐ Donation 5 ☐ Other (Special) 21. SIGNATURE OF FUNESAL SERVICE LIC		UAKLA	ND C			ADDRESS			WAL	DORF	, MAF	RYLAND	\dashv
	THE HUNTT FUNERAL HOME. INC.													
	BENJAMIN M.	MATTHEWS	M-0065	8	P.	Ō. I	30X 15	56 W	ALDO	RF, M	ARYL	AND 2	20604	
	23. PART i. Enter the diseases, or c shock, or heart fellure.	omplications the	et caused the de- use on each line	ath. Do	not enter 1	hs mod	is of dying	, such s	es cerdi	ec or respi	ratory ar	rest,	Approximate Interval Between	en
	Onest as												Onset and Dec	
_ 1	OUE TO (OR AS A CONSEQUENCE OF)													
CERTIFICATION	Sequentially list conditions, DUE TO (OR AS A CONSCOUENCE OF):													
SAT	If sny, lesding to immediate cause. Enter UNDERLYING													
IFI	CAUSE (Disesse or Injury that initieted events	DUE TO	OR AS A CONSEC	DUENCE C	F):								=	
ERT	resulting in deeth) LAST													
	PART II. Other significent condition	s contributing to	D deeth but not re	esulting	In the und	erivina	ceuse giv	en in Pe	ert I.	24a. WAS AN	AUTOPSY	24b.	WERE AUTOPSY FINDING	GS
CAL	Athers Scher									PERFOR	MED?		AVAILABLE PRIOR TO COMPLETION OF CAUSE	
ED					W 1	-ua	~		-	t TYES 2	M NO		OF DEATH?	
Σ.	DID TOBACCO USE CONTI	RIBUTE TO CA	AUSE OF DEA	TH Y	ES 🗆 N	ОΠ	UNCER	RTAIN					1 YES 2 NO	
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL				TH (Check or									\exists
Sic	EXAMINER?	HOSPITAL:	☐ ER/Outpatient 3	□ DOA	OTHER:		5 🗆 Resid	dence 8	☐ Other	(Specify)				
ЭНУ	27. MANNER OF DEATH	28s. DATE O	F INJURY Day, Year)	28b, Til	IE OF 2	8c. INJU		2	ed. DES	CRIBE HOW I	NJURY OC	CURED		\neg
ВУ	1 Natural 5 Pending 2 Accident Investigation	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	-,.		М	1 🗌 Y		Ю						
ED E	3 Suicide 8 Could not be	28e. PLACE building	OF INJURY — At ho	me, fsrm,	street, factor	y, office		2		TION (Street a	nd Numbe	r or Rural A	oute Number,	
ETE	4 Homicide determined													
IPL.	29s. CERTIFIER (Check only 1 CERTIFYING PHYSI													
COMPLET	one) 2 MEDICAL EXAMINE	R: On the beels of	examination end/or i	investigati	on, in my op	Inion, de	ath occured	at the fin	me, dats	and placs, en	d dus to t	he cause(s)	and manner as stated.	
ш	29b. SIGNATURE AND TITLE OF CERTIFIE	R					29c. LICENS	SE NUMBI	ER		29d. DA	TE SIGNED	(Month, Day, Year)	
TO B	Koluman	MD					D40	653	3.3		•	12	12/95	
F	30. NAME AND ADDRESS OF PERSON WHD COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)													
	Valerie Solomon, M.D. 11345 Pembrooke Square Suite 104 Waldorf, Maryland 20603													
	31. DATE FILED (Mooth) Day Year) 199!	32. REGISTA	WILLIAM A	ardal	l									

x 00

DIVISION OF VITAL RECORDS, P.O. BOX 6876

	1 - STATE REGISTRAR	STATE OF N		DEPAR					MENTA	REG. NO.	E				
	1. DECEDENT'S NAME (First, Middle, La Lillian	carroll			St	vann			MONT	OF DEATH	1005	YEAR	3. TIME OF DEATH 11:00 A M		
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. la	st birthday)	IF UNDER		IF UNDER	1 24 HRS.	7. DATE	OF BIRTH	1775		IPLACE (State or Foreign		
	218-30-4422	YRS.	MONTHS	DAYS	HOURS	MIN.	AUG	1. Day (bar)	1906	MA	RYLAND				
TOR	9e. FACILITY NAME (If not institution, gi		96. CITY	, TOWN C	R LOCATE	ON OF DE	ATH		9c. COUN	TY OF D	DEATH				
<u>ق</u> ا	Physicians Memorial		La Pl	lata					Char:	les					
ធ្ន	RESIDENCE OF DECEDENT 10e. STATE 10b. COU	10c. CI1	ry, town (OR LOCAT	ION						10d, INSIDE CITY				
	MARYLAND CF	NA	NJEM	YC							LIMITS?				
AL	10e. STREET AND NUMBER					101	ZIP COD	E			10g. CITI	ZEN OF	WHAT COUNTRY?		
<u> </u>	BOX #404 POSEYI				2066					TED :	STATES				
à	11. MARITAL STATUS 1 Never Merried 2 Merried 3 Widowed 4 Divorced	12. WAS DECEDEN FORCES? 1 IF YES, GIVE W	YES 2	RMED NO		If yes, sp		m, Mexica	n, Puerto	f? (Specify Yes Rican, atc.)	or No-	14, RACI Blac Spec	E — American Indien, k, White, etc. #y: BLACK		
	15. DECEDENT'S E (Specify only highest gi	EDUCATION		ECEDENT'S				ng.	168	. KIND OF BU	SINESS/IND	USTRY	2223011		
<u> </u>	Elementary/Secondary (0-12)	College (1-4 or 5	-) #4	e. Do NOT u	ise retired.)			'W				_			
MP	7TH GRADE 17. FATHER'S NAME (First, Middle, Last)		EXI	PLOSI	VE W	ORKE				GOVER		ני			
	ALBERT CARROLL									Middle, Meiden ATCHER)V	1.00		
0	19e. INFORMANT'S NAME (Type/Print)		11	96. MAILIN	G ADDRES	S (Street e				ber, City or Tow					
ᄋᆝ	EVELYN SWANN									JEMOY,			D 20662		
	20e. METHOD OF DISPOSITION 1 X Burlel 2 Cremetton 3 F 4 Donatton 5 Other (Specify)	lemoval from State	20b. PLACE cemetery, cr	ANDDATE	OF DISPOS	SITION (Na	me of		DAT	E 20c. LO	20c. LOCATION — City or Town, State				
	21. SIGNATORE OF FUNERAL SERVICE	DRIVION JOHN	Arso	~	22. T	NAME AN	ON ADDRE	SS OF FA	RAL	HOME,	P.A.	,	EAD, MD.2064		
	23. PART I. Enter the diseases,	or complications the	t couved the d	eath. Do		-			_			_	Approximate		
										Interval Between Onset and Death					
_		DUE TO (OR AS A CONSEQUENCE (OF):													
	Sequentielly list conditions, If sny, leading to immediate DUE TO (OR AS A CONSEQUENCE OF):														
2	CAUSE (Disease or injury														
	that initieted avents resulting in deeth) LAST		DUE TO (OR AS A CONSEQUÊNCE OF												
핑		d													
¥	PART ii. Other significent condi	tions contributing to	deeth but not	resulting	in the u	nderlyin	csuse	given in	Part i.	ert i, 24s. WAS AN AUTOPSY PERFORMED?			D. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO		
										1 TES 2	THO		OF DEATH?		
L CERTIFICATION TO BE COMPLET	DID TOBACCO USE COI	NTPIRLITE TO CA	LISE OF DE	ATH V	ES []	NO F	1 LING	CERTAI	N \square				1 TYES 2 NO		
Y	25. WAS CASE REFERRED TO MEDICA			CE OF DE			0140	LKIA							
	1 YES 2 NO	HOSPITAL:	ER/Outpatient	3 🗆 DOA	OTHE		e 5 🗆 R	esidence	8 🗆 Othe	er (Specify)					
	27. MANNER OF DEATH 1 Netural 5 Pending 2 Accident Investigation	28e. DATE OF (Month, E	INJURY lay, Year)	28b. TH	ME OF JURY M	WC	INJURY AT WORK?			28d. DEŞCRIBE HOW INJURY OCCURED					
	2 Accident unvestigation 3 Suicide 8 Could not be determined 4 Homicide determined 28e. PLACE OF INJURY — At home, term, street, fectory, or building, stc. (Specify)							Ilice 28t. LOCATION (Street end Number or Rurel Route Number, City or Yours, State)					Roule Number,		
MPLE	anal .	HYSICIAN: To the best of											A		
	2 MEDICAL EXAMINER: On the beele of exemination end/or investigation, in 29b. SIGNATURE AND/TITLE OF CERTIFIER									ona piace, ei					
∞	mula a 1,	Ital, m	り					ENSE NUI 21/131	MOEN		29d. DATE SIGNED (Month, Day, Year)				
임	30. NAME AND ADDRESS OF PERSON	WHD COMPLETED CAU	SE OF DEATH (IT	EM 27) (Typ	D 21031							, , , ,			
	Michael Leatherwood	1. MD. Waldor	f Medical	Park	PΛ	Rov	2/O 1.1	a1do~	f M	mrland (00607	02/0			
	31. DATE FILED (Month, Day, Year)	32. REGISTR	R'S SIGNATURE			1117	Wa	LUION	, 178	y raun		1//19			
	UEC 0 6 19	95 Julia	Davilson	Cardal	4										



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BOX 68760	
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31. DATE FILED (Month, Day, Year)

'95

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. 1. OECEDENT'S NAME (First, Middle, Last) 2. DATE OF OEATH Diffenderter YEAR 1999 Alica JC+0 De R Scherer 11:43 AM 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign 178.03-9623 8 4 1 M 2 F NOV 29 PENNSYLVANTA 1910 permit, Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number, 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Memoria Harford 0/4 AJICE PIAID RESIDENCE OF DE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? MARYLAND CECIL EARLEVILLE 1 YES 2 X NO 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 80 N. DRIVE 21919 USA funeral director, page 5 should be detached for use as the burlal-transit retained by the hospital or attending physician, 13. WAS OECENOENT OF HISPANIC ORIGIN? (Specify Yea or No—
H was anselfy Cuban, Mexican, Puerto Rican, etc.) 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 14. RACE — American Indian, Black, White, atc. 1 Never Married 2 Married 1 YES 2 NO Specify: BY 3 X Widowed 4 Divorced Specify: WHITE ETED 16e. DECEOENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EOUCATION 16b. KIND OF BUSINESS/INDUSTRY /Spi College (1-4 or 5+) COMPL 12 SECRETARY-BOOKEEPER HARDWARE 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Malden Sumame) 75 ELMER DIFFENDERFER ELLEN MAY KERLIN notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 JAMES SCHERER 67 MIDWAY DRIVE, EARLEVILLE, MD. 21919 death. Page 6 may be pe 20a. METHOD OF DISPOSITION
1 ☑ Buriel 2 ☐ Cremation 3 ☐ Ramoval from State OATE 20c. LOCATION — City or Town, State 20b. PLACE AND DATE OF DISPOSITION (Name of must Cemetery, crematory of other place.

LIMERICK GARDEN OF MEMORIES 10-80-95 Donation 5 _Other (Specify) LIMERICK, PA. examiner 21. SIGNATURE OF TINERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY FELLOWS FUNERAL HOME Jary 226 E. MAIN ST. CECILTON, MD. completely filled in by the 21913 hours after 23: PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. medical **Approximate** Interval Between ŏ IMMEDIATE CAUSE (Finel Onset and Death the PREMIONIA cremation, disease or condition event, resulting in death) QUE TO (OR AS A CONSEQUENCE OF) in and con to burial, Consu traumatic CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF) if any, leading to immediate attending physician cause. Enter UNDERLYING CAUSE (Disease or injury other DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 10 been signed by the atte injury, PART II. Other algorificent conditions contributing to death but not resulting in the underlying cause given in Part i. MEDICAL 24a. WAS AN AUTOPSY 24b, WERE AUTOPSY FINDINGS CONGESTIVE REART FAILURE AVAILABLE PRIOR TO COMPLETION OF CAUSE ATT 1 TYES 2 NO OF DEATH? requires shows CEREBRAL VISCUM ARVINEWY NIBAN 1 TES ZNO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES | NO | UNCERTAIN PHYSICIAN: After this certificate has b death with the State Dept. 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) Hem EXAMINER? HOSPITAL: OTHER: Inpatient 2 ER/Outpatient 3 DOA 4 - Nursing Home 5 - Residence 6 - Other (Specify) 6 27. MANNER OF OEATH 28a. DATE OF INJURY (Month, Day, Year) 26b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED marked, 1 Natural 5 Pending М 1 YES 2 NO BY 2 Accident 28s. PLACE OF INJURY — At home, term, streat, factory, office building, atc. (Specify) 3 Sulcide .00 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 8 Could not be DIRECTOR: / 4 Homicide 28 determined hours item 29a. CERTIFIER 1 DCERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and piece, and due to the cause(a) and manner as stated. FUNERAL I -TO THE HOSPITA
TO THE FUNERA
DE filed within 72
IMPORTANT: II the basis of examination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(e) and manner as stated. 29b. SIGNATURE AND TITLE OF BENTIFF 29d. DATE SIGNED (Month, Gay, Year) BE 29c. LICENSE NUMBER 10 25 5 WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 30. NAME AND AODRESS OF PERSON , Und (MIDI XVA

relia Davidson-Randall

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DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 25 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNEAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygher prior to burial, cremation, or removal.

IMPORTANT: If them 28 is marked, or New 23 shows any Iniury, or other traumatic event, the madical examinar must has marked, or New 25 shows any Iniury, or other traumatic event.

	Amended B	ox rue,	190,	10d,	ΤŢ	/ 2 1 /	95 (Л•Г	. Ke	ent	95	38	3015
	FOR 1 - STATE REGISTRAR	STATE OF M		DEPAR					MENTAI				
	1. DECEDENT'S NAME (First, Middle, Last)				IOAI	LOI	DLAI	-		REG. NO).		
	Elizabeth A		~~1						MONTH	1 0	MY	YEAR	3. TIME OF DEATH
	4. SOCIAL SECURITY NUMBER									ember	14,1		10:55 A M
		1 M 2 XXF	6. AGE (In yrs. In		MONTHS	DAYS	IF UNDER	24 HRS.	7. DATE (Month	OF BIRTH		8. BIRTHP Country	PLACE (State or Foreign
	086-03-2879	88	YRS.			5-011/-02	11.64	Marcl	1 6,19	907	New	York	
~	9a. FACILITY NAME (If not institution, give				-		OR LOCATIO		EATH		9c. COU	INTY OF DE	ATH
6	°Heron Point He	alth Care	Facili	ity		Ches	terto	own			:	Kent	
	RESIDENCE OF DECEDENT	γ		10c CIT	Y TOWN	OR LOCAT	ION						10d. INSIDE CITY
DIRECTOR	Maryland		ster						- 1	LIMITS?			
	10e. STREET AND NUMBER				OHC		. ZIP CODE				40- 017		1 X YES 2 NO
FUNERAL	421 ХЖМХККХ Н	(D- *				101					10g. CI I		
1 2	11. MARITAL STATUS			DIVED	- 40		216	_		No. 181		USA	
	1 Never Married 2 Married	12. WAS DECEDENT FORCES? 1	YES 2	HWED	13.	If yes, spe	ecify_Cuber	n, Maxica	n, Puerto F	? (Specify Yellican, etc.)	s or No-	14. RACE Black,	- American Indian, White, atc.
B	3 Widowed 4 Divorced	IF YES, GIVE WI	AR OR DATES			1 TYES	2XXN0	Specify	<i>(</i> :			Specify	White
B	15. DECEDENT'S EDU		18a, DE	ECEDENT'S	USUAL	OCCUPATIO	ON		16h	KIND OF BU	SINESS/INI	DUSTRY	WILLEC
	(Specify only highest grad	e completed) College (1-4 or 5+)	(G	Give kind of a	work done	during mo	st of working	g	1			5007711	
7	200000000000000000000000000000000000000	4	Adr	mini XXX	str	atic	n			Insur	2200	Co	
COMPLETED	17. FATHER'S NAME (First, Middle, Last)							TER'S NA	ME (First. A	fiddle, Maiden		00.	
E C	John M. Spetn	age1								abeth	,		
00	19a. INFORMANT'S NAME (Type/Print)		19	b. MAILING	ADDRES	S (Street a							
2	The state of the s											1 01600	
S	20- METHOD OF DISPOSITION												
	1 Donation 5 Other (Specify)	noval from State	a a secondary of the		44 -1-			. 15		5 Do			m, state
5	21. SIGNATURE OF FUNERAL SERVICE LI	CENSEE /	Joapie	<u>ar</u> 01	22	NAME AN	D ADDRES	S OF FAC	CIUTY	סע וכי	ver,	De.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Fellows-Wells Funeral Home													
413 High St. Chestertown, Md. 21620									21620				
									Approximata interval Between				
	IMMEDIATE CAUSE (Fine)											Onset and Death	
-	disease or condition resulting in death)	. PANCRE	EATIC	CAI	VC E	=R							3 months
		DUE TO (OR AS A CONSE	OUENCE O	F):								
Z	Sequentielly ilst conditions.												
ERTIFICATION	if any, leeding to immediate couse. Enter UNDERLYING												
2 2	CAUSE (Diseese or injury	c.	OR AS A CONSE	OUENOE O	_								
E	that initiated events resulting in death) LAST	000 10 (OH AS A CONSE	QUENCE O	rja								
5 0								·					
5 I	PART II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert i. 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS												
MEDICAL										PERFO			AVAILABLE PRIOR TO COMPLETION OF CAUSE
ij									_		110		OF DEATH?
	DID TOBACCO USE CONT	RIBUTE TO CAL	JSE OF DEA	ATH YE	SΠ	NO X	UNC	ERTAIN					10 2/2/10
₹	25. WAS CASE REFERRED TO MEDICAL			CE OF DEAT									
S	EXAMINER?	HOSPITAL:	ER/Outpatient 3	DOA	OTHE 4 M.Nu		e 5 □ Ras	aldence	6 Other	(Specify)			
PHYSICIAN:	27. MANNER OF DEATH	28a. DATE OF I		26b. TIM	E OF	28c. INJU	URY AT	1			OW INJURY OCCURED		
ВУР	1 Natural 5 Pending 2 Accident Investigation	(Month, Day	y, rear)	INJ	M	1 Y	FIK?	NO					
	2 Accident Investigation 3 Suicide 6 Could not be	28a. PLACE OF	INJURY - At ho	ome, farm, s	street, fec	tory, office			281. LOCA	TION (Street	and Number	or Rural Ro	ute Number,
日日	4 Homicide determined	Sullaing, if	tc. (Specify)						City o	or Town, State)			
COMPLET	29a. CERTIFIER 1 CERTIFYING PHYS	ICIAN: To the best of n	ny knowledne de	eath occur-	ed at the	time deta	and place	and dur	to the co	an(a) and =	DDA4 22 -1 -1	lad	
. WE	(Check only one) 2 MEDICAL EXAMINI												and manner as stated
	29b. SIGNATURE AND TITLE OF CERTIFIE									2			
H		The m.					29c. LICE	HI5	_				Month, Day, Year) 4 - 95
2	30. NAME AND ADDRESS OF PERSON WI			M 27) (Tenn	Onine)		D	117	0			1 - 1	1-13

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

Chestertown,

Md.

Julia Davidson-Randole

21620

Speer Rd.

'95

122

NOV 21

31. DATE FILED (Month, Day, Year)

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within a feath. Page 6 may be retained by the hospital or attending physician.

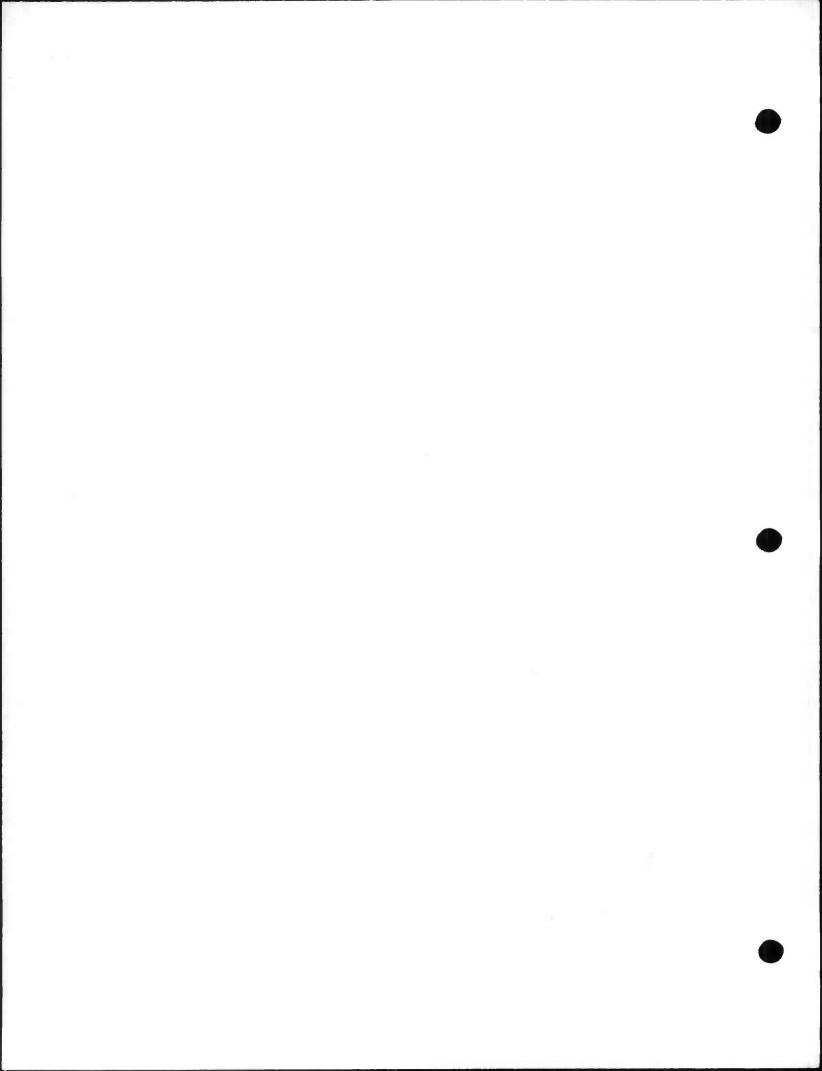
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1. 2. 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial. cremation. or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

FOR 1 - STATE

	REGISTRAR		CERTIFI	CATE O	F DEATH	REG. NO						
	1. DECEDENT'S NAME (First, Middle, Last) JULIA MAY	SNYDER				2. DATE OF DEATH DO NOVEMBER	30,1995°	3. TIME OF DEATH				
OR	L	5. SEX 6. AGE (In 7	7. DATE OF BIRTH	te of Birth onth, Day, Year) LY 24,1919 8. BIRTHPLACE (State or Country) MARYLANI								
	90. FACILITY NAME (If not institution, give str 13302 BLAIRS VA				OR LOCATION OF DE	ATH	9c. COUNTY O					
5	RESIDENCE OF DECEDENT					0	MASI	TINGTON				
DIRECTOR		SHINGTON		LEAR S	SPRING			10d. INSIDE CITY LIMITS? 1 YES 2 NO				
FUNERAL	100. STREET AND NUMBER 13302 BLAIRS VA	ALLEY ROAD			101. ZIP CODE 21722		U.S.A.					
BY FUN	11. MARITAL STATUS t Never Married 2 Merried 3X Widowed 4 Divorced	12. WAS DECEDENT EVER IN U FORCES? 1 YES IF YES, GIVE WAR OR DATE	2 NO	If yes,	ECENDENT OF HISPAN specify Cuban, Mexice ES 2 NO Specify	IIC ORIGIN? (Specify Yes n, Puerlo Rican, etc.)	or No- 14. R	ACE — American Indian, leck, White, etc.				
	15. DECEDENT'S EDUC. (Specify only highest grade of	completed)	6a. DECEDENT'S ((Give kind of w Ille. Do NOT use	ork done during	TION most of working	16b, KIND OF BUS	SINESS/INDUSTRY					
COMPLETED	Elementary/Secondary (0-12)	College (1-4 or 5+)		EMAKE			N HOME					
BE CO		MAS LEA	SURE		16. MOTHER'S NA	ME (First, Middle, Meiden IE MAE	Sumame) BLO	YER				
10	190. INFORMANT'S NAME (Type/Print) GERALDINE M. S	SWORD				Poute Number, City or Town						
	20s. METHOD OF DISPOSITION 1) Suries 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION /Name of Lemmatory or other place 20c. LOCATION — City or Town, State											
	1A. Burlei 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) BLAIRS VALLEY CEMETERY 12-2-95 CLEAR SPRING, MARYLA 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY											
	· R. hoel	Brady	Y	AND	REW K. COF	FMAN FUNEF	RAL HOME	, INC.				
	40 E. ANTIETAM ST, HAGERSTOWN, MD. 21740 23. PART I. Enter the diseases, or complications the caused the deeth. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between											
	IMMEDIATE CAUSE (Final disease or condition resulting in death) a. Aur Myocard (Archiver New York) a. Aur Myocard (Archiver New York) a. Aur Myocard (Archiver New York)											
NOI	Sequentially list conditions, if any, leading to immediate b. CRUNANY MTGY DISCASE DECADLE DECADLE											
CERTIFICATION	cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events CAUSE (Disease or injury CAUSE (Disease or injury											
CERT	resulting in death) LAST											
EDICAL	PART II. Other algorithms Conditions	PERFOR	PERFORMED? AMAR									
Σ	1 YES 2 NO											
PHYSICIAN:	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 2. 26. PLACE OF DEATH (Check only one)											
YSIC	1 TYES 2 NO	HOSPITAL: 1 Inpatient 2 ER/Outpati	ent 3 🗆 DOA	OTHER: 4 - Nursing H	ome 5 Besidence	a Cther (Specify)						
ВУ РН	27. MANNER OF DEATH 1 Netural 5 Pending 2 Applicant Investigation	28e. DATE OF INJURY (Month, Day, Year)	28b. TIME INJU	IRY \	NJURY AT YORK? YES 2 NO	28d. DESCRIBE HOW II	JURY OCCURED					
	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide datermined 28e. PLACE OF INJURY — At home, farm, street, lectory, office building, stc. (Specify) 28f. LOCATION (Street and Number or Rural Route Number, City or Town, Stete)											
COMPLETED		IAN: To the best of my knowled										
8	2 MEDICAL EXAMINER	: On the beele of examination e	nd/or Investigation	, in my opinion	death occured at the	time, date end place, en	d due lo lhe ceus	e(e) and manner ee stated.				
TO BE	The Mary Centuries	+ FAMICE		CICAN	29c. LICENSE NUM	7	DATE SIGN	(Month, Day, Year)				
	STEPHENTE: N	COMPLETED CAUSE OF DEATH	1 (TEM 27) (Type,	f7 Nu	THOW H	te the	En Itel	n, and				
	TI-DATE OF FO (Management) of 1	PERSONAL SISHONAL	URE									



TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to bunial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	FOR 1 - STATE REGISTRAR	STATE OF MARYL	AND / DEPARTI			MENTAL HYGIEN	E				
	1. DECEDENT'S NAME (First, Middle, Lest) William Eugene SF	'ICKLER,Sr.				2. DATE OF DEATH DA	1 1995	3. TIME OF OEATH			
BY FUNERAL DIRECTOR	4. SOCIAL SECURITY NUMBER 217-16-2970	SOCIAL SECURITY NUMBER 5. SEX 1 M 2 F 78 YRS. 8. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year) Sept. 24, 191									
	90. FACILITY NAME (If not Institution, give si Washington County RESIDENCE OF DECEDENT			Hagers	TOWN	АТН	Washing				
	10a. STATE 10b. COUNTY	ngton		rstown	ON		L				
	100. STREET AND NUMBER 11439 ROCK Hill R	load		101.	ZIP CODE 21740		10g. CITIZEN OF WHAT COUNTRY? USA				
	11. MARITAL STATUS 1 Never Married 2 X Merried 3 Widowed 4 Divorced	12, WAS DECEDENT, EVER IF FORCES? 1 (A) YES IF YES, GIVE WAR OR O. WWII	2 NO		cify Cuban, Maxica	IIC ORIGIN? (Specify Yea n, Puerlo Rican, etc.)	Bla	ck, White, etc.			
COMPLETED	15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12)	CATION	16a. DECEDENT'S US (Give kind of won life. Do NOT use n Expedite)	k done during mos etired.)	N It of working	50,000,000	+ Manuf				
	9 17. FATHER'S NAME (First, Middle, Lest) Thomas Bernerd Sp	ickler	Expedite			ME (First, Middle, Maiden ice Hollin	Surname)	curing			
TO BE	190. INFORMANT'S NAME (Type/Print) Pauline M. Spickl				nd Number or Rural i	Route Number, City or Town agerstown,	n, State, Zip Code))			
	20s. METHOD OF DISPOSITION 1 W Burlel 2 Cremetion 3 Removel from State 4 Donation 5 Other (Specify) 20s. PLACE AND DATE of DISPOSITION (Name of Congress) Cremetion (Specify) 20s. PLACE AND DATE of DISPOSITION (Name of Congress) Cremetion (Specify) 20s. PLACE AND DATE of DISPOSITION (Name of Congress) Congress (Specify) 20s. PLACE AND DATE of DISPOSITION (Name of Congress) Congress (Specify) 20s. PLACE AND DATE of DISPOSITION (Name of Congress) Congress (Specify) 20s. PLACE AND DATE of DISPOSITION (Name of Congress) Congress (Specify) 20s. PLACE AND DATE of DISPOSITION (Name of Congress) Congress (Specify) 20s. PLACE AND DATE of DISPOSITION (Name of Congress) Congress (Specify) 20s. PLACE AND DATE of DISPOSITION (Name of Congress) Congress (Specify) 20s. PLACE AND DATE of DISPOSITION (Name of Congress) Congress (Specify) 20s. PLACE AND DATE of DISPOSITION (Name of Congress) Congress (Specify) 20s. PLACE AND DATE of DISPOSITION (Name of Congress) Congress (Specify) 20s. PLACE AND DATE of DISPOSITION (Name of Congress) Congress (Specify) 20s. PLACE AND DATE of DISPOSITION (Name of Congress) Congress (Specify) 20s. PLACE AND DATE of DISPOSITION (Name of Congress) Congress (Specify) 20s. PLACE AND DATE of DISPOSITION (Name of Congress) Congress (Specify) 20s. PLACE AND DATE of DISPOSITION (Name of Congress) Congress (Specify) 20s. PLACE AND DATE of DISPOSITION (Name of Congress) Congress (Specify) 20s. PLACE AND DATE of DATE of Congress (Specify) 20s. PLACE AND DATE of Congress (Specify) 2										
	21. SIGNATURE OF PUNERAL SERVICE LIC	-Olen	_		ne Funer Conococ	al Home heague St.	21 Williams	THPLACE (State or Foreign roty) Tyl and Tod, INSIDE CITY LIMITS? 1 YES 2 (A) NO F WHAT COUNTRY? A ICE — American Indian, set, White, etc. Sec. White, etc. Sec. White, etc. Sec. White, etc. Sec. Maryland 1795 Approximata Interval Between Onset and Death 1795 Approximata Interval Between Onset and Death 1795 Town, Stata T, Maryland 1795 Sport, MD Approximata Interval Between Onset and Death 1795 Town, Stata T, Maryland 1795 Sport, MD Approximata Interval Between Onset and Death 1795 Town, Stata T, Maryland 1795 Sport, MD Approximata Interval Between Onset and Death 1795 Town, Stata Town, Stata T, Maryland 1795 Sport, MD Approximata Interval Between Onset and Death 1795 Town, Stata Town, Stata Town, Stata Town, Stata T, Maryland 1795 Sport, MD Approximata Interval Between Onset and Death 1795 Town, Stata Town, Stata T, Maryland 1795 Sport, MD Approximata Interval Between Onset and Death 1795 Town, Stata T, Maryland 1795 Town, Stata T, Maryland 1795 Sport, MD Approximata Interval Between Onset and Death 1795 Town, Stata T, Maryland 1795 Town, Stata Town,			
	ahock, of heart failure. List only pracease on each line. IMMEDIATE CAUSE (Final disease or condition resulting in dasth) August full much and full full full full full full full ful										
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated avents resulting in death) LAST										
MEDICAL	Kenal Failure Decen 1 time Kilher VOLCERED 1 VES 2 1/10										
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:		THER:	5 🗆 Residence	8 Dither (Specify)					
ВУ РН	27. MANNER OF DEATH 1 Natural 5 Pending 2 Accident Investigation	28s. DATE OF INJUSTY (Month, Day, Mar)		ES 2 NO		E HOW INJURY OCCURED					
	3 Suscide 1 Could not be determined	25e, PLACE OF INJURY building, etc. (Spe	отуј	- 10		BH. LOGATION (Street a City (or Timers, State)		Abute Number			
COMPLETED	(Check only one) 2 MEDICAL EXAMINE	ICIAN: To the best of my know						o(s) and manner as stated.			
TO BE	29b. SIGNATURE AND TITLE OF CERTIFIE 30. NAME AND ADDRESS OF PERSON WH	Sulate	M. 0		29c. LICENSE NUI	2174	≥ /Q/	(Month, Dey, Year)			
	350 MILL 31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGN	GERS70	ner	MD	2174	0				
	DFC 11995 Sh	SE REGISTRAR'S SIGN	M.								

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.C. BC	The law requires that the death certificate be executed within
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200	PHYSICIAN:
DIVISION OF VITAL RECORDS, P.O. BOX 88760	SPITAL OR ATTENDING PHYSICIAN: The Is
5	8
	SPITAL

		FOR 1 - STATE REGISTRAR	STATE OF N			RTMENT				MENTAL	HYGIEN	_			
		1. DECEDENT'S NAME (First, Middle, Last)						DEA		2. DATE	OF DEATH	AY	YEAR	. TIME OF DEATH	_
		ROSALIA SPADAFORA								DECE	6:00 P	м			
		4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. les	st birthday)	IF UNDER		IF UNDER		7. DATE	Dey, Year)		995 8. BIRTHP	LACE (State or Foreign	2
B		120-16-5537	1 □ M 2 🏻 F	99	YRS.	MONTHS	DAYS	HOURS	MIN.	JUNE	14,	1896	Country)	ALY	
Should	-	9e. FACILITY NAME (If not institution, give				9b. CITY,	TOWN	OR LOCATI	ON OF DE	ATH		9c. COU	TY OF DE	ATH	
1, 2, 3	СТОВ	REEDERS MEMORIA				BOON	ISBOR	10		1	WASHI	NGTON			
Pages	1 W	10a. STATE 10b. COUNT		10c. CIT	Y, TOWN O	R LOCAT	TION						od. INSIDE CITY		
.#i	DIR	MARYLAND WASHINGTON				(6)		ROH	RERS	VILL	Ε		1	LIMITS?	
permit.	3AL	10e. STREET AND NUMBER					101	r. ZIP CODI	E			10g. CITI	ZEN OF WH	AT COUNTRY?	
physician. burial-transit	FUNER	4423 MAIN STREET			_				217				U.	S.A.	
physician. burtal-trar	5	11. MARITAL STATUS 1 Never Merried 2 Merried		YES 2 XI						NC ORIGIN	(Specify Yellican, atc.)	or No-		- American Indian, White, atc.	
	₩	3 🔀 Widowed 4 🗌 Divorced	IF YES, GIVE W	AR OR DATES									Specify:	WHITE	
r attending use as the	0	15. DECEDENT'S EDUCATION 18e. C				USUAL OC	CUPATIO	ON		16b.	KIND OF BU	SINESS/IND	USTRY	AMILITIE	_
- 6 -	Ш	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 8+)			ive kind of a Do NOT us	work done o se ratired.)	luring mo	st of working	ng						
3 2 8	COMPL	8	8			SEAMSTRESS					DRES	S MA	NUFAC	TURING	
2 9 E	👨	17. FATHER'S NAME (First, Middle, Lest)						18. MOTI	HER'S NAI	ME (First, M	liddle, Meiden	Surneme)			
od by	BE	DOMENICK GIARDII	VIERI								ANUELI				
retained 5 should notified	0	19a. INFORMANT'S NAME (Type/Print)									er, City or Tow				
									ROH				•	21779	
		20e. METHOD OF DISPOSITION 1 X Burlel 2 Cremetion 3 X Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of cametery, crametory or other place) 20c. LOCATION — City or Town, State 20c. LOCATION — City or Town, State 20c. LOCATION — City or Town, State													
9 6 5		4 Donation 8 Other (Specify) ST RAYMOND S CEMETERY 12/5/95 BRONX, NEW YORK 22. NAME AND ADDRESS OF FACILITY													
death, Pag funeral di f. examiner	Ē	Paul M. Dean BAST FUNERAL HOME 7606 Old National Pike												,	
- E G	Ь.	1 auc 111-12	xcer-		25.50	5-7					Boon	sboro	, MD	21713	
5 = 2		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, ahock, or heart failure. List only one cause on sech line. Approximate Interval Batween												en	
		IMMEDIATE CAUSE (Fine) disease or condition													
d withings ompletely fills 1, cremation, event, the		reaulting in death)	a. Sur	OR AS A CONSE	elect	e								10 days	2
a light	_	otherna Canadi-													
9 0 E	CATION	Sequentially list conditions, if any, leading to immediate b.													
ysician prior trau	8	cause. Enter UNDERLYING CAUSE (Disease or Injury													
certificate ding physi lygiene pr other to	ERTIFI	that initiated events	DUE TO (OR AS A CONSEC	DUENCE OF	F):									
E 5 - 6	H	resulting in death) LAST	d												
를 로마 마	LC	PART ii. Other aignificent conditione contributing to death but not resulting in the underlying cause given in Part i. 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FIND												FRE AUTOPSY FINDING	GS.
	5										PERFOR	MED?	A	WAILABLE PRIOR TO OMPLETION OF CAUSE	
requires been signe of Health	MEDICA									-	F DEATH?				
beer of	2	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN										YES 2 NO			
9 2 2	PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?				TH (Check o				To Land					-
SICIAN: The certificate the State in the State i, or item	Si	1 VES 2 NO	HOSPITAL:	ER/Outpatient 3	□ DOA	OTHER 4 Nurs		e 5 🗆 Re	sidence	8 🗆 Other	(Specify)				
ATTENDING PHYSICIAN: ECTOR: After this certifica is after death with the St 1 28 is marked, or it	표	27. MANNER OF DEATH	28e. DATE OF (Month, De		28b, TIM	_	28c. INJ	_			RIBE HOW I	NJURY OCC	URED		
DING PHYSI After this c death with	ВУ	1 Natural 5 Pending 2 Accident Investigation	-			М		/ES 2 [] NO						
TTENDIN TOR: Af after de 28 is r	ED	3 Suicide 8 Could not be 4 Homicide determined	28e. PLACE OF building, o	INJURY — At ho etc. (Specify)	me, ferm, ı	street, fecto	ry, office	•		281. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
OR ATTENDING DIRECTOR; After hours after death	<u></u>														
TAL OR A AL DIRECT 72 hours 11 item	릴		CIAN: To the best of a												
	COMPL	one) 2 MEDICAL EXAMINE	R: On the besis of ex	amination end/or i	rwestigatio	n, in my op	dinion, de	eath occur	ed at the t	ime, date a	ind place, en	d due to the	cause(e) a	nd menner es stated.	
TO THE HOSPI TO THE FUNER Be filed within	BE C	29b. SIGNATURE AND TITLE OF CERTIFIE	R //	1_				29c. LICE	NSE NUM	BER		29d. DATE	SIGNED (A	lonth, Day, Year)	\dashv
DE SE	TO E	KT	welend)					Do	325					5	
	_	30. NAME AND ADDRESS OF PERSON WH													
		Dr. R. Guedenet			ne, K	eedy:	svil	lle,	MD	2175	6				
		DEC 4 1995	RECOSTRAF	R'S DIGNATURE											
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THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. To the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Memtal Hygiene prior to burial, cremation, or removal. TO BE COMPLETED BY FUNERAL DIRECTOR IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL	HYGIENE
CERTIFICATE OF DEATH	REG. NO.

FOR 1 - STATE REGISTRAR	STATE OF MARYL		ENT OF HEALTH AND ATE OF DEATH	MENTAL HYGIEN REG. NO.	E	
1. DECEDENT'S NAME (First, Middle, Last)				2. DATE OF DEATH		3. TIME OF OEATH
OTIS	George	SHRIVER		November	26, 199	
4. SOCIAL SECURITY NUMBER		In yrs. lest birthday) IF	UNDER 1 YEAR IF UNDER 24 HRS.	7. DATE OF BIRTH	6. BH	RTHPLACE (State or Foreign
216-22-9611 9e. FACILITY NAME (If not institution, give s	1 M 2 F 68	YRS.	THE DAYS HOURS MIN.			West Virginia
Memorial Hospital			Cumberland		Alleg	any
10e. STATE 10b. COUNTY	1	10c. CITY, TO	WN OR LOCATION		- 77	10d. INSIDE CITY
Maryland Wash	ungton	Hand	erstown			1 VES 2 NO
10e. STREET AND NUMBER		1 Dags	10f. ZIP CODE		10g. CITIZEN C	OF WHAT COUNTRY?
Ray St.			21740		- 11	S A
11. MARITAL STATUS	12. WAS DECEDENT EVER II	U.S. ARMED	13. WAS DECENDENT OF HISPA If yes, specify Cuban, Mexic		or No- 14. R	ACE — American Indian, llack, White, etc.
1 Never Married 2 Merried 3 Widowed 4 Divorced	FORCES? 1 YES	ATES	1 TES 2 NO Speci			pecify:
15. DECEDENT'S EDU				Line was seen	1	White
(Specify only highest grade	completed)	(Give kind of work life, Do NOT use ret	done during most of working	16b. KIND OF BUS	INESS/INDUSTR	Y
Elementary/Secondery (0-12)	College (1-4 or 5+)	Laborer		Puial		
17. FATHER'S NAME (First, Middle, Last)		Laborel	18 MOTHER'S N.	AME (First, Middle, Meiden	Compa	nu
Arthur B. Shriver			100000000000000000000000000000000000000			
19e. INFORMANT'S NAME (Type/Print)		19b. MAILING ADI	DRESS (Street and Number or Rural	Belle Rank)
Kathleen E. Muir			St. Hagerston	VIIII A		,
, 20s. METHOD OF DISPOSITION	206					r Town, State
XIX Burial 2 Cremation 3 Ram 4 Donation 5 Other (Specify)	oval from State	netery, cremetory or other	Pomotonii Nou	29 05 40	one town	w Manufaud
21. SIGNATURE OF FUNERAL SERVICE LIC	CENTRE	si naven c	lece) emetery Nov. 22. NAME AND ADDRESS OF FA	ICILITY 1050	E D. U	n, Margaunu
I I Journe	1/17		22. NAME ANÓ ADDRESS OF FA Davis Funera	e Home 1252	.5 Bradi	owry Ave.
23. PART I. Enter the diseases, or	complications that cause	t the death. Do not	inter the mode of duling au	SIIV	cristiani,	Approximate
ahock, or heart failura.	Liat only one cause on e	ach line.		or ev carares or reap	atory arrow,	Interval Batween Onset and Death
disease or condition reaulting in death)	a. Carbac a	CONSEQUENCE OF:	niet			3 days
Sequentially list conditions, if any, leading to immediate	DUE TO (OR AS A	CONSEQUENCE OF):				
cause, Enter UNDERLYING CAUSE (Disease or Injury	С.					
that initiated eventa	DUE TO (OR AS A	CONSEQUENCE OF):				
resulting in death) LAST	d					
PART ii. Other significant condition	a contributing to death b	out not reaulting in the	ne underlying cause given in	Part I. 24s. WAS AN	AUTOPSY	24b. WERE AUTOPSY FINDINGS
Dementia				PERFOR	MED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE
COPD				1 TYES 2	NO	OF DEATH?
DID TOBACCO USE CONT	RIBUTE TO CAUSE C	DE DEATH YES	□ NO □ UNCERTA	N.FT		1 YES 2 NO
25. WAS CASE REFERRED TO MEDICAL		28. PLACE OF DEATH (
EXAMINER?	HOSPITAL:		THER: ☐ Nursing Home 5 ☐ Residence	8 ☐ Other (Specify)		
27. MANNER OF DEATH	28e. DATE OF INJURY	28b. TIME O	28c, INJURY AT	26d. DESCRIBE HOW I	NJURY OCCURE	D
1 Netural 5 Pending	(Month, Day, Year)	INJURY	M 1 YES 2 NO	150		
2 Accident Investigation 3 Suicide 8 Could not be	28e. PLACE OF INJURY building, etc. (Spe	/ — At home, ferm, stree	t, tectory, office	281. LOCATION (Street	and Number or Ru	iral Route Number,
4 Homicide determined	ounding, etc. (Spe	Cityy		City or Town, Stete)		
290. CERTIFIER 1 CERTIFYING PHYS	ICIAN: To the best of my know	riedge, death occurred a	the time, date end piece, end du	e to the ceuse(s) end ma	nner es stated.	
onel			my opinion, death occured at the			se(s) end manner ee stated.
29b. SIGNATURY AND TITLE OF CONTIFIE	A A		29c. LICENSE NU	IMBER	29d. DATE SIG	NED (Month, Day, Year)
1 1160	rich		D 2891			ber 28 1995
30. NAME AND ADDRESS OF PERSON WH	O COMPLETED CAUSE OF DE	ATH (tTEM 27) (Type, Prin		. •	HOVEI	IDEL OC U 1777
Dr. HC Merrick, M	emorial Hosp	ital Medic	al BldgCumb	erland. MD	21502	
31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGN	ATURE	ar brage, oum	Caldid, III	21302	
DEC 11995 56	i Maritan Rul	M				
		-	·			

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

	MEGIGTIAN				CAIL	IDEATH		HEG. NO.			
	1. DECEDENT'S NAME (First, Middle, Last)					· · · · · ·	2. DA	TE OF DEATH	ν -	YEAR 3.	TIME OF DEATN
	WILLIAM EAR	L STOUR	FFER					11 2	9	95 1	1:58 AH
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. las	st birthday)	IF UNDER 1 YEA	-	(0.4)			8. BIRTHPLA Country)	CE (State or Foreign
	217-09-9561	1 🔀 M 2 🗌 F	91	YRS.	MONTHS DAY	S HOURS M		r. 6, 19	904		RYLAND
	9a. FACILITY NAME (If not institution, give st	reet and number)		9b. CITY, TOV	N OR LOCATION (9c. COUNTY OF DEATH			
NO I	WASHINGTON COUNTY	HOSPITA	T.			HAGERS'	TOWN		WASHINGTON		
DIRECTOR	RESIDENCE OF DECEDENT 10a, STATE 10b, COUNTY				CITY, TOWN OR LOCATION						
E I				10e. CH		_				I, INSIDE CITY LIMITS?	
	MARYLAND 100. STREET AND NUMBER	WASHING	STON STON	1	CH	IEWSVILL	E				YES 2 X NO
FUNERAL						10f. ZIP CODE			10g. CIT	IZEN OF WHA	
	21103 TWIN SPRING						21721			U.S.	
5	11. MARITAL STATUS 1 Never Merried 2 Married	12. WAS DECEDENT FORCES? 1	T EVER IN U.S. AF			DECENDENT OF H , specify Cuban, M			or No-	14. RACE Black, W	American indian, hite, atc.
B	3 Widowed 4 Divorced	IF YES, GIVE W	AR OR DATES		1 🗆	YES 2 XNO	Specify:			Specify:	WHITE
- 1	15. DECEDENT'S EDUC	CATION	180 05	CEDENT'S	USUAL OCCUP	ATION	T:	16b. KIND OF BUS	INECC/IN	Dijetov	MUTTE
Ë I	(Specify only highest grade	completed)	(G		vork done during	most of working	- 1	IOD. KIND OF BOS	1114633/114	DOSTRI	
P	Elementary/Secondary (0-12)	College (1-4 or 5 +	.)	T.	ABORER			MOOD	TREA	יויו/יבואידי	COMPANY
COMPLETED	17. FATHER'S NAME (First, Middle, Last)				THO TWIN	18. MOTNER	'S NAME (First	st, Middle, Meiden		TIME	COMPANI
	THOMAS STOUFFE	R					XY SNY				
BE	19e. INFORMANT'S NAME (Type/Print)		19	b. MAILING	ADDRESS (Str	eet and Number or F			n. Stete. Zi	n Gode)	
유	EFFIE E. STOUFF	ER	I E	2.0. 1	BOX 30	, CHEWSV	ILLE.	MARYLA	ND	21721	
	20a. METHOD OF DISPOSITION				OF DISPOSITION					City or Town,	State
	1 X Buriel 2 Cremation 3 Ramo 4 Donation 5 Other (Specify)	oval from Stata	BEAVE	R CRI	ther place)	ÆTERY	12/1/				MARYLAND
	21. SIGNATURE OF VUNERAL SERVICE CO.	ENSEE	Tara to 1	ar Ord		E AND ADDRESS (
	Foul Mich	2-	Paul M.	Dear	n BAS	FUNERA	L HOM	H:		Natio	nal Pike 21713
	23. PART I. Enter the diseases, or o	complications that	t caused the de	eath. Do n	not enter the	mode of dying,	such ss c				Approximats
	shock, or heart fellure.	List only one ceu	ise on each line	θ.							Intervel Between Onset and Death
	disesse or condition	5,	nsic								124
	resulting in desth)	DUE TO	ON AS A CONSE	QUENCE OF	F):						121
z		h									
CERTIFICATION	Sequentially list conditions, If any, leeding to immediate	DUE TO	(OR AS A CONSE	OUENCE OF	F):						
CA	cause. Enter UNDERLYING CAUSE (Disesse or Injury	c.									
	thet initiated events	DUE TO	(DR AS A CONSE	OUENCE OF	F):						
ER	resulting in desth) LAST	d									
	PART II. Other significent condition	s contributing to	deeth but not	resulting i	In the under	ying ceuse give	n In Part I.	24a. WAS AN	AUTOPSY	24b. WE	RE AUTOPSY FINDINGS
EDICAL	Afrescherth	1 CAN	diomic	ular	1 de	une		PERFOR		AM	MILABLE PRIOR TO MPLETION OF CAUSE
								1 TYES 2	□ NO	DF	DEATH?
Σ	DID TOBACCO USE CONTI	PIRLITE TO CA	LISE OF DE	ATH YE	S D NO	INICED.	TAIN 🗆			11	YES 2 AO
AN	25. WAS CASE REFERRED TO MEDICAL	KIBOIL TO CA			TN (Check only		IAII4				
<u>i</u>	EXAMINER? 1 YES 2 NO	HOSPITAL:			OTHER:						
PHYSICIAN:	27. MANNED OF DEATH	28a. DATE OF		28b. TIM		Nome 5 Reside		ther (Specify) DESCRIBE NOW II	N ILIBY OF	CHIBED	
	1 Natural 5 Pending	(Month, D			IURY	WORK?		DESCRIBE NOW I	NOONT OC	CONED	
BY	2 Accident Investigation	28a, PLACE O	F INJURY — At h	Ome term /				OCATION (Street a	and Numbe	or Promi Bout	Mumber
E	3 Suicide 8 Could not be 4 Nomicide determined	bullding,	atc. (Specify)		and an industry,	ome	201. 0	City or Town, State)	and reambe	or Heral House	I Walliow,
	29a. CERTIFIER			55	700 - 100						
COMPLET	(Check only										
8	2 MEDICAL EXAMINE	()	xamination and/or	Investigatio	n, in my opinie	on, death occured i	at the time, d	late and place, an	d dua to t	he cause(a) an	d manner as stated.
BE	29b. SIGNATURE AND THE OF CENTRIES	1 N				29c. LICENS	E NUMBER	-30		TE SIGNED (M	_
6	11/10					104	272	0	P /	1-29	7-75
	30. NAME AND ADDRESS OF PERSON WN) Caa.	TACE	1111 1	110	2121	. 2
	31. Party Elice (Month, Day Your)	22911:	AR SIGNATURE	7.0	ムレレル	3,01	INID	nre, v	40	21+	2
	40 1 0 1332 Am	AK KURUSUSUSUS	Of 14 1/2								

FOR STATE REGISTRAR

JOSEPH

1. DECEDENT'S NAME (First, Middle, Last)

1:01

BIRTNPLACE (State or Foreign Country)

MD (Vite

PM

, 1995

9c. COUNTY OF DEATN

REG. NO. 2. DATE OF DEATH DAY

ECEMBER

P.O. BOX DIVISION OF VITAL RECORDS,

4. SOCIAL SECURITY NUMBER 7. DATE OF BIRTH 5 -20 - 1934 5. SEX 6. AGE (In yrs. lest birthdey) IF UNDER 1 YEAR IF UNDER 24 HRS DAYS HOURS 216-30-4439 1 XM 2 - F 60 Pages 1, 2, 3 should 9e. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWH OR LOCATION OF DEATH DIRECTOR PRINCE GEORGES HOSPITAL CENTER CHEVERLY 10c. CITY, TOWN OR LOCATION Newburg permit. 10a STREET AND NUMBER FUNERAL 101. ZIP CODE 606 Medowview Dr. 20664 use as the burial-transit 24 hours after death. Page 6 may be retained by the hospital or attending physician. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1X YES 2 NO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-If yee, specify Cuban, Mexicen, Puerlo Ricen, atc.)

1 YES 2 KNO Specify: 1 Never Merried 2 Merried 1957-01963 BY 3 Widowed 4 X Divorced 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16e. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY COMPLET Elementery/Secondary (0-12) è College (1-4 or 5+) Car Salesman 5 should be detached 16. MOTNER'S NAME (First, Middle, Meiden Sumeme) 17. FATHER'S NAME (First, Middle, Last) Wilmer Clarence Thompson Elsie L. Farrell Thompson notified at 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code, Joseph Wilmer Thompson, Jr. 14 Maple St. Indian Head, MD 20640 pe 20e. METNOD OF DISPOSITION

A Burlel 2 Cremetion 3 Removal from State
4 Donation 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of must funeral director, MD"Veterans Cem. 12/7/95 Cheltenham, MD examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE AREHART-ECHOLS FUNERAL HOME.INC. M00945 P.O. Box 567 LaPlata, MD 20646 Davis in by the f medicai 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiec or respiratory street, completely filled in by shock, or heart fallure. List only one cause on each line 0 IMMEDIATE CAUSE (Finel the cremation. disease or condition Multiple Injuries
Due to (OR AS ACONSEQUENCE OF) event, resulting in death) HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed prior to burial, traumatic CERTIFICATION and Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF) If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury other DUE TO (OR AS A CONSEQUENCE OF): thet initiated events resulting in death) LAST 10 the atter Injury, PART II. Other algoriticent conditions contributing to deeth but not resulting in the underlying cause given in Part i. 24e, WAS AN AUTOPSY PERFORMED? signed by the any 1 YES 2 NO shows a DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐ UNCERTAIN ☐ has be Dept. 1 PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATN (Check only one) certificate h HOSPITAL:
1 | Inpatient 2 | ER/Outpatient 3 | DOA **EXAMINER?** 1 YES 2 ND OTHER: 4 - Nursing Nome 5 - Residence 0 26e. DATE OF INJURY (Month, Day, Year) 12/3/95 26b. TIME OF 27. MANNER OF DEATH 28c. INJURY AT WORK? r this c 28d, DESCRIBE HOW INJURY OCCURED marked, 1 Netural
2 Necident motorvehicle 1015 AM 1 YES 2 NO After the BY 26e. PLACE OF INJURY — At home, term, street, tectory, office building, etc. (Specify) 69 3 Sulcide 6 Could not be COMPLETED DIRECTOR: / street 28 4 Nomicide Item 29e. CERTIFIER
(Check only one)

1 CERTIFVING PNVSICIAN: To the best of my knowledge, death occurred at the time, date end piece, end due to the cause(e) and more one) FUNERAL within 72 h TO THE HOSPITA
TO THE FUNERA
De filed within 72
IMPORTANT: 19 2 TMEDICAL EXAMINER: On the basic of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner so stated. 29c LICENSE NUMBER BE Cherte my O.C.M.E. 9 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DENNIS 111 Penn Street, Baltimore, Maryland 21201 31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE Julia Daucher Revoll DEC 0

WILMER

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

THOMPSON

PRINCE GEORGES 10d. INSIDE CITY 1 YES 2 XNO 10g. CITIZEN OF WHAT COUNTRY? U.S.A. 14. RACE — American Indian, Black, White, etc. Specify: White Auto DATE 20c. LOCATION — City or Town, State Approximats Interval Between Onset and Death 24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO collision 261. LOCATION (Street and Number or Rural Apute Number, 29d, DATE SIGNED (Month, Day, Year) DECEMBER 4,1995

Pages 1, 2, 3 should

permit.

use as the burial-transit

funeral director, page 5 should be detached for

and completely filled in by the burial, cremation, or removal.

prior to l

physician

attending

the atten

Health and

this certificate has been with the State Dept. of

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31. DATE FILED (Month, Day, Year)

DEC 0 1 1995

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(687	executed
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O. B(ertificate
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S. D.	death
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OR	that
RECORDS, P.O. BOX 6876	requires
4	JAW
T	The
OF VITAL I	YSICIAN:
\equiv	포
VISION OF	ATTENDING
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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH November 28, 1995 YEAR 1:20 PM TARZIA Bruno 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 6. BIRTHPLACE (State or Foreign May 2, 1904 Ttaly 063-09-8384 1XXM 2 - F 91 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH Citizens Nursing Home Frederick Frederick DIRECTOR RESIDENCE OF DECEDENT 10b. COUNTY 10a. STATE 10c. CITY, TOWN OR LOCATION Frederick 10d. INSIDE CITY Maryland Frederick 1 YES XX NO 109. CITIZEN OF WHAT COUNTRY? U.S.A. 10e. STREET AND NUMBER FUNERAL 101. ZIP CODE 21702 7219 Rainbow Lane 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. PAMED FORCES? 1 VES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No—If yea, specify Cuban, Maxican, Puerto Rican, etc.)

1 YES X NO Specify: 14. RACE — American Indian, Black, White, atc. 1 Never Married 2 Married 3 Widowed 4 Divorced 2 Married Specif White BY ETED 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only hig Elementary/Secondary (0-12) College (1-4 or 5+) Clerical/ Office Railroad COMPL once. 17. FATNER'S NAME (First, Middle, Last) 18. MOTNER'S NAME (First, Middle, Maiden Surname) Catherina Stramandinoli Tarzia 4 Dominick notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
7219 Rainbow Lane, Frederick, Md. 21702 2 James Moore 90 20a. METNOD OF DISPOSITION
1 ☐ Burlel 2 ☐ Cremation 3 ☐ Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 29, must 1995 Smithsburg, Md. 4 Donation 5 Other (Specify) examiner 22, NAME AND ADDRESS OF FACILITY
Keeney and Basford P.A. Funeral Home 21. SIGNATURE OF FUNERAL SERVICE LICENSEE MO0255 106 East Church St., Frederick, Md. 21701 medical 23. PART I. Enter the diseases, or complications that deused the death. Do not enter the mode of dying, such as cardiec or respiretory arrest, Approximata shock, or heart fellure. List only one ceuse on each line **IMMEDIATE CAUSE (Final Onset and Death** the disease or condition ATHEROSCIEROTIC CARDIOVASCILLAR 10 YRS reaulting in death) other traumatic event, DUE TO (OR AS A CONSEQUENCE OF) CERTIFICATION Sequentleily ilat conditiona, DUE TO (OR AS A CONSEQUENCE OF) if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF) that initiated eventa resulting in death) LAST 10 PART II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part i. 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS PERFORMED? AMAII ARLE PRIOR TO any RENAL INSUFFICIENCY, COPD COMPLETION OF CAUSE OF DEATN? . DIABETES 1 YES 2 NO Shows MELLITUS 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \(\square\) NO \(\square\) UNCERTAIN \(\square\) PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATN (Check only one) Item HOSPITAL:
1 | Inpatient 2 | ER/Outpetlant 3 | DOA OTHER:
4 Nursing Name 5 Residence 6 Other (Specify) 1 YES 2 NO 0 27. MANNER OF DEATN 28e. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 28b. TIME OF INJURY 28d. DESCRIBE NOW INJURY OCCURED marked, 1 Natural 5 Pending Investigation 1 YES 2 NO L DIRECTOR: After the bours after death villem 28 is mari BY 2 Accident 26e. PLACE OF INJURY — At home, term, street, factory, offica building, atc. (Specify) 28t. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Sulcide 8 Could not be 4 Homicide 29a. CERTIFIER

1 CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as attended. COMPL TO THE FUNERAL DI be filed within 72 ho IMPORTANT: If Its 2 MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occured at the time, date end place, and due to the ceuse(e) end menner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) Andrew O. Donelson ma D 21936 Nov. 29, 1995 30. NAME AND ADDRESS OF PERSON WNO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. Andrew O. Donelson, MD 915 Toll House Avenue, Frederick, Maryland 21701

32. BEGISTRAS'S SIGNATURE RANGELL

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physicial	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunial-transit permit. Pages 1, 2, 3 be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to bunial, cremation, or removal.	MADOUTANT: 6 House 20 In secondary on these 20 about the secondary described about the secondary
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	FOR 1 STATE	STATE OF I	MARYLAND /	DEPAR	RTMEN	T OF H	IEALTH	AND	MENTAL HYGIE	NE		
	REGISTRAR		CI	ERTIF	ICAT	E OF	DEA	TH	REG. N	O.		
	1. DECEDENT'S NAME (First, Middle, Last)								2. DATE OF DEATH	0.44		TIME OF DEATH
	RICARDO	THOM	nA-5						MONTH /28	DAY 95	YEAR	4 Am
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. les	t birthday)	IF UNDER	1 YEAR	IF UNDER	24 HRS.	7. DATE OF BIRTH	175	A. BIRTHPLA	ACE (State or Foreign
	579-71-1120	1 M 2 F	LLA	YRS.	MONTHS	DAYS	HOURS	MIN.	(Month, Day, Year)	055	Country)	446
	9a. FACILITY NAME (If not institution, give st		70						July 25,1		100	MD
00	A COLOR OF THE STATE OF THE STA	-5%	-				OR LOCATI				TY OF OEAT	H
DIRECTOR	MYATTSUILLE	MANO	R		m	147	750	NEE	MD	1	6	
្ត	RESIDENCE OF DECEDENT 100. STATE 10b. COUNTY	,		1 400 017	Y, TOWN	201001	TON.					
=	The state of the s	06						_ 7			10	d. INSIDE CITY LIMITS?
		9		7	3/2/	HE	1410	イ 人 ス	& MD		1	YES 2 NO
FUNERAL	10e. STREET AND NUMBER					101	ZIP COD	E		10g. CITIZ	EN OF WHA	T COUNTRY?
一声	4718 GUNTA	HER S.	T,			- 1	20	743	3		USA	
15	11. MARITAL STATUS	12 WAS DECEDEN	T EVED IN ILE AD	MED	13.	WAS DEC	ENDENT (OF HISPAN	NIC ORIGIN? (Specify	fes or No-	14. RACE	American Indian, hite, etc.
	1 Never Merried 2 Merried	IF YES, GIVE W	YES 2	40			ecify Cubs		IT, Puerto Rican, etc.)		Black, W Specify:	hite, etc.
B	3 Widowed 4 Divorced						- 02	opeon	,.		Blac	lr
0	15. DECEDENT'S EDUC	ATION	16a. DE	CEDENT'S	USUAL O	CCUPATIO	ON		16b, KINO OF B	USINESS/INDI		N.
	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4 or 5		ive kind of Do NOT u	work done se retired.)	during mo	st of working	ng				
7	10	0011090 (1-4-01-0-1		o Med	rhan:	ic			Self-e	mn l ove	Б	
COMPLETED	17. FATHER'S NAME (First, Middle, Last)	***	1.20.0	0 110	JIICHII.		10 MOT	HED'C NA	ME (First, Middle, Maid	_	·u	
	James D. Thomas,	Tr								,		
BE	19a, INFORMANT'S NAME (Type/Print)	UI.		- 1	-				d L. Pride			
2			12	1718	Gunt	S (Street a.	St.re	or Rural I	Route Number, City or R	own, State, Zip	Code)	
-	Mildred Thomas-Sl	ye		apit	al F	eigh	its.	MD	20743			
	20e. METHOD OF DISPOSITION 1 St Burlal 2 Cremation 3 Remo	oval from State	20b. PLACE / cemetery, cre	AND DATE	OF OISPOS	SITION (Na	me of		DATE 20c. I	OCATION - C	Hty or Town,	State
	4 Donation 6 Other (Specify)		Maryla	and l	Vat1	Mer	m. Pa	ark	12/2 Lau	rel,	MD.	
	21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEE			22.	NAME AN	O ADDRE	SS OF FA	CILITY			
1	MIRSMALL	1.00							meral Hor			
\vdash	y. v. riwis	rece			4	308	Suit	lanc	Rd., Su	tland	, MD :	20746
	23. RART i. Enter the diseases, or c shock, or heart fellure. I	omplications the liet only one cau	t ceused the de ise on each line	eth. Do i	not enter	the mo	de of dy	ing, suc	h es cardiac or res	piratory sm	st,	Approximate interval Batween
	IMMEDIATE CAUSE (Finel		1		. 4	1			1			Onset and Death
	disesse or condition resulting in death)	FCALL	W M	ANN	0 W	Mu	ma	n of	MUMM	/		MALL
		THE TO	(OR AS 'A CONSEC	DUENCE O	F):	11		1	1			
z	and the state of t					V		1				
RTIFICATION	Sequentially list conditions, if any, leading to immediate	DUE TO	(OR AS A CONSEC	DUENCE O	F):			1				
181	cause. Enter UNDERLYING											
	CAUSE (Disease or injury that initiated events	DUE TO	(OR AS A CONSEC	DUENCE O	F):							
분	resulting in deeth) LAST	1-										
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1	PART II. Other significant conditions	contributing to			In the ur	derlying	cause (given in	Part i. 24a. WAS A	N AUTOPSY		RE AUTOPSY FINDINGS
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MEDICAL			1		(- 1.23	2 [] 110		DEATH?
	1		-		1				-		11	YES 2 NO
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL											
일	EXAMINER?	HOSPITAL:			OTHE		ACE OF D	EATH (Ch	eck only one)			
X	1 YES 2 NO	1 Inpetient 2						sidence	8 Other (Specify)			
품	27. MANNER OF DEATH 1 Natural 5 Pending	28a. DATE OF (Month, D		28b. TIM	E OF URY	28c. INJU			26d. OESCRIBE HOW	INJURY OCC	JREO	
B	1 Natural 5 Pending 2 Accident Investigation				M		'ES 2 [NO				
	3 Suicide 6 Could not be	26e. PLACE O building.	F INJURY - At horetc. (Specify)	me, farm, s	street, fact	ory, office	•		281. LOCATION (Stree City or Town, Stet	t and Number o	r Rural Route	Number,
ETE	4 Homicide determined	74							City of rown, State	-,		
ايرا	29s. CERTIFIER CERTIFYING PHYSIC	IAN: To the best of	my knowledge, de	ath occurr	of at the s	ime, plate	and place	and due	to the couse(s) and m			
COMPL									to the cause(s) and m time, date and place, o			
8		- 1			1000				The state of the state of the state of the	San San San San	300,000	A STANCE OF THE PARTY.
BE	291 SIGNATURE AND TITLE OF CERTIFIER	LAM	AM				29th LICE	NSE NUM	nen l	26d. DATE	SIGNED (MA)	rith. Day, New!
0	ann min	Jan V	VVV				201	144		T P M	W.W	1991
	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CALL	TE OF DEATH OVER	4 DT /T	C 1 43							



MD- 6201 Greenbelt Road, College Park, MD 20740

Lewis Dennis,
31. DATE FILED (Morith, Day, Year)
DEC . 1 1995

32. REGISTRAR'S SIGNATURE

AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

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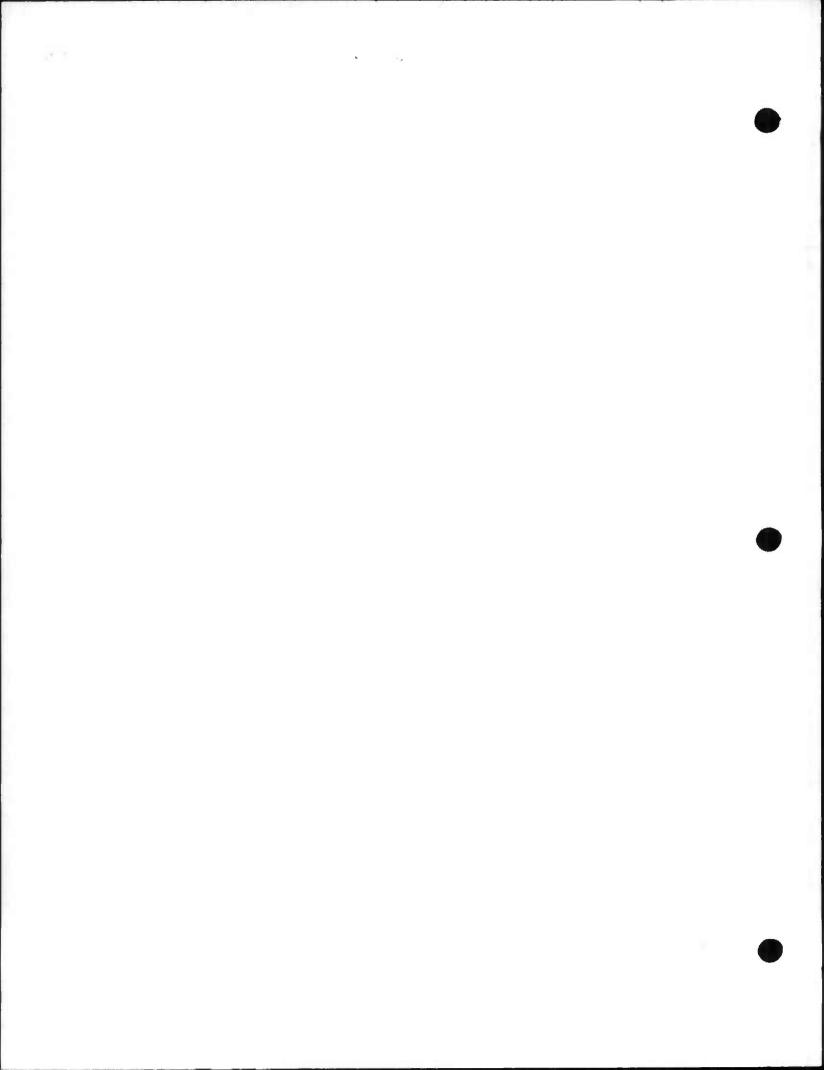
Stored yourself look Markey !

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DEC 1 1335 gain annual resident

BALTIMORE, MARYLAND 21215-0020	I hours after death. Page 6 may be retained by the hospital or attending physician.	L DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. P. Pours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.
DIVISION OF VITAL RECORDS, P.O. BOX 68760	L. OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within Z4 hours after death. Page 6 may be retained by the hospital or attending physician.	L DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the 2 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

	1 - STATE REGISTRAR	STATE OF MARYL							
	t. DECEDENT'S NAME (First, Middle, Last)	AR CERTIFICATE OF DEATH NAME (First, Middle, Lest) Yn Elizabeth Tucker Sex 6. AGE (In yrs. lest birthday) F UNDER 1 YEAR F UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign							
		h Tucker							1930 PM
	4. SOCIAL SECURITY NUMBER	Charles and the same of the sa				(Month, Day, Year)		Country)	
	219-44-1721 9a. FACILITY NAME (If not institution, give s	37.33	/9 YRS.		OR LOCATION OF D	Jan.12,	1916	Mary	
DIRECTOR	Kent & Queen Anne	's Hospital		Chester			Ken		"
EC	10a. STATE 10b. COUNT		10c. CITY,	TOWN OR LOCA	TION				d. INSIDE CITY
	Maryland Kent	Queen Ann	e Che	estert	own			200	LIMITS? YES 2 NO
RAL	100. STREET AND NUMBER	D 3		1.0	f. ZIP CODE		100		T COUNTRY?
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	1 Never Married 2 Married	FORCES? 1 YES	2 X NO	If yes, sp	ecify Cuban, Maxica 2 NO Specif	in, Puerto Ricen, etc.)	s or No- 14	Black, W Specify:	American Indian, hita, etc.
D BY	3 Widowed 4 Divorced			1	- <u>Z</u>			V.	White
ETED	15. DECEDENT'S EDU (Specify only highest grade	completed)	16a. DECEDENT'S U (Give kind of wo life. Do NOT use	ork done during mo		16b. KIND OF BU	SINESS/INDUS	TRY	
	Elementary/Secondary (0-12)	College (1-4 or 5+)	Office		or	Const	ructi	on	
COMP	17. FATHER'S NAME (First, Middle, Last)		OTTICE	Manag		ME (First, Middle, Malden		OII	
BE	J. Rouse Story				Elva	Comegys			
2	19a. INFORMANT'S NAME (Type/Print)		19b. MAILING /	ADDRESS (Street a		Floute Number, City or Tow	n, State, Zip C	ode)	
	David Tucker					Chester			
	12 Buriel 2 Cremetion 3 Rem 4 Donation 8 Other (Specify)	oval from State Cen	netery, crematory or oth	er place)		0ATE 20c. LO			
	21. SIGNATURE OF FUNERAL SERVICE LIC	CENSEE 7	nesteri.	TETO C	OHIETELY ND ADORESS OF FA	11/6 Ce Funeral	ntrev	1116	e,MD
	suf of	Reldent	ein			Funeral hesterto			21620
	23. PART I. Enter the diseases, or	complications that cause	d the deeth. Do no						Approximate
	ahock, or heart fallure. IMMEDIATE CAUSE (Final	List only Dne cause on e	ach line.						Interval Between Onset and Death
	disease or condition resulting in death)	. Pres	menia						28645
			CONSEGUENCE OF	efters					210 0112
CATION	Sequentially list conditions,	Bronds OUE TO (OR AS A	CONSEQUENCE OF		15				89 4413
CAT	if any, leading to immediate cause. Enter UNDERLYING		V. 17.00 P. 10.00 P.					į	İ
ERTIFIC	CAUSE (Disease or Injury that initiated events	OUE TO (OR AS A	CONSEQUENCE OF)	:					
CER	resulting in death) LAST	d				.			
	PART II. Other algolificant condition	a contributing to death b	out not resulting in	the underlying	g cause given in	Part I. 24s. WAS AN			RE AUTOPSY FINDINGS
DICA	In tranonia	1 hemonlage	- E (B) 4	conigas	-1'5 - 1m.	n to PERFOR	0	COL	MPLETION OF CAUSE DEATH?
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PHYSICIAN:	EXAMINER?	HOSPITAL:		OTHER:					
¥	27. MANNER OF DEATH	1 → Impatient 2 □ ER/Outp	28b. TIME	OF 28c, INJ		8 Other (Specify) 28d. DESCRIBE HOW I	NJURY OCCU	9FO	
ВУ Р	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	INJU		PIK? YE\$ 2 NO				
ED B	3 Suicide 8 Could not be	28a. PLACE OF INJURY building, atc. (Spec	— At home, larm, str	reet, factory, office	•	281. LOCATION (Street a	and Number or	Rural Route	Number,
1	4 Homicide determined								
MPL		CIAN: To the best of my know R: On the basis of examination							
8	29b. SIGNATURE AND TITLE OF CERTIFIEF		T STADOT INVESTIGATION,	in my opinion, o					
BE	Same of Certifier	Con con			D170		29d. DATE S		nth, Day, Year)
유	30. NAME AND ADDRESS OF PERSON WHO	COMPLETEO CAUSE OF DE	ATH (ITEM 27) (Type, F	Print)					
	Sus ANK, Ross	MD 516	Washing	too Are	Che, +	in from M	d a	160	20
12	NOV 7 '95	JA. HEGISTHAN S SIGN	ATURE - Randelle						



2. DATE OF DEATH

Dec. 3,

7. DATE OF BIRTH (Month, Day, Year

DATE

8 Other (Specify)

D43083

21797

Specify

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

MARIE

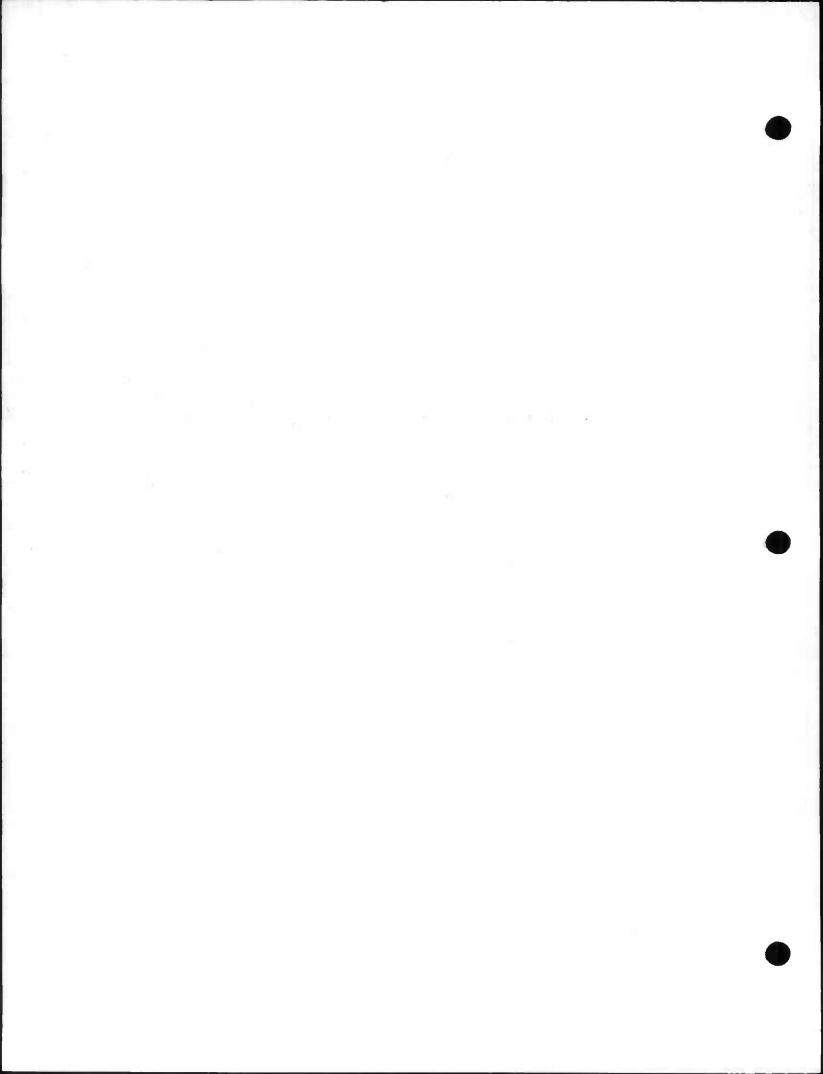
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VIRGINIA

4. SOCIAL SECURITY NUMBER 5. SEX 8. AGE (In yrs. last birthday IF UNDER 24 HRS. 213-60-5555 43 permit. Pages 1, 2, 3 should 9e. FACILITY NAME (If not institution, give street end number 9b. CITY, TOWN OR LOCATION OF DEATN DIRECTOR 2605 Rt. 97 Glenwood RESIDENCE OF DECEDENT 10c. CITY, TOWN OR LOCATION Maryland Woodbine Carrol1 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE completely filled in by the funeral director, page 5 should be detached for use as the burial-transit inial, cremation, or removal. 15915 Old Frederick Road 24 hours after death. Page 6 may be retained by the hospital or attending physician. 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No—If yes, specify Cuben, Mexican, Puerto Ricen, atc.) FORCES? 1 YES 2 NO 1 Never Merried 2 Merried 1 TES 2XXNO BY 3 Widowed 4 Divorced ED 15. DECEDENT'S EDUCATION 18e. DECEDENT'S USUAL OCCUPATION (Specify only highest ET Elementary/Secondery (0-12) College (1-4 or 5 +) COMPL Teacher 17. FATNER'S NAME (First, Middle, Last) notified at John T. Bower 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Frances R. Gosnell Bower 90 20e. METHOD OF DISPOSITION
1 M Buriel 2 ☐ Cremation 3 ☐ Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of must 4 ☐ Donation 5 ☐ Other (Specify) Lake View Memorial Park 12/6/95 Sykesville, Maryland examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEI medical 23. PART L Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. IMMEDIATE CAUSE (Final the disease or condition metastatic breast cancer resulting in death) HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within traumatic event, DUE TO (OR AS A CONSEQUENCE OF) burial, and CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): prior to if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury the attending physician I Mental Hygiene prior to other DUE TO (OR AS A CONSEQUENCE OF): that initiated events reaulting in death) LAST 0 PART II. Other aignificant conditions contributing to death but not resulting in the undarlying cause given in Part i. MEDICAL Health and any Shows t of H DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN has be Dept. PHYSICIAN: 23 26. PLACE OF DEATN (Check only one) 25. WAS CASE REFERRED TO MEDICAL this certificate h with the State [HOSPITAL 1 YES 2 NO Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Nome 5 Infectionce -27. MANNER OF DEATN 28e. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? marked, 1 Natural 5 Pending 1 YES 2 NO BY FUNERAL DIRECTOR: After twithin 72 hours after death 2 Accident 28e. PLACE OF INJURY — At home, lerm, street, factory, office building, atc. (Specify) 3 Sulcide 28 is i COMPLETED 4 Homicide TO THE HOSPITAL OR ATT TO THE FUNERAL DIRECTE be filed within 72 hours at IMPORTANT: If Item 29 29e. CERTIFIER
(Chack only

CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) end menner as atsted. 2 MEDICAL EXAMINER: On the beele of exemination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(e) end menner es stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER BE a. 20402- WD traile 9 30. NAME AND ADDRESS OF PERSON WNO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. George A. Sotos, M.D. 10605 Concord St. Kensington, MD 31. DATE FILED (DEC 32. REGISTRAR'S SIGNATURE
July Davelson Rawlall

3. TIME OF DEATH YEAR 1995 2:15 P.M.M 8. BIRTHPLACE (State or Foreign May 1, 1952 Maryland 9c. COUNTY OF DEATH Howard 10d. INSIDE CITY 1 - YES 2 1 NO 10g. CITIZEN OF WHAT COUNTRY? United States 14. RACE — American Indian Black, White, etc. Specify White 16b. KIND OF BUSINESS/INDUSTRY Education 18. MOTNER'S NAME (First, Middle, Meiden Surneme) Frances R. Gosnell 15915 Old Frederick Road Woodbine, MD 21797 20c. LOCATION - City or Town, State 22. NAME AND ADDRESS OF FACILITY Stauffer Funeral Homes, P.A 8 East Ridgeville Blvd. Mt. Airy, MD 21771 Interval Between Onset and Death 13.5 months 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS PERFORMED? AWAILABLE PRIOR TO COMPLETION DF CAUSE 1 TYES 2 THO 1 YES 2. NO 28d. DESCRIBE NOW INJURY OCCURED 281. LOCATION (Street end Number or Rural Route Number, City or Town, State) 29d. DATE SIGNED (Month, Day, Year) DECEMBER 5, 1995



Virginia

hould

FOR STATE REGISTRAR

4. SOCIAL SECURITY NUMBER

579-54-4143

9s. FACILITY NAME (If not institution, give street and number)

1. DECEDENT'S NAME (First Middle, Last)

5. SEX

1 - M 2 XF

TO.	Prince George	's Hospital	everly	F	rince G	eorge's	
AL DIREC	MD Prince George's Landover 10. The THEET AND NUMBERS 608 BL Paso Street 10. The AND STREET AND NUMBERS 608 BL Paso Street 10. The And STREET AND NUMBERS 10. The And STREET AND NUMBER	INSIDE CITY LIMITS?					
		COUNTRY?					
B	1 Never Married 2x Married	FORCES? 1 YES 2 1	IO If ye	s, specify Cuban, Maxican, P		Black, White	te, atc.
<u> </u>	(Specify only highest grade	College (1-4 or 5+)	ive kind of work done durin Do NOT use retired.)	g most of working			
-			reactive 2	16. MOTHER'S NAME	First, Middle, Maiden Surn		
TO BE	19a. INFORMANT'S NAME (Type/Print)	19		reet and Number or Rural Route	Number, City or Town, St		0785
er must be	20a. METHOD OF DISPOSITION 1 X Burlel 2 Cremation 3 Rem	oval from State 20b.PLACE cemetery, cre	AND DATE OF DISPOSITIO matory or other place)	N (Name of	DATE 20c. LOCATI	ON — City or Town, S	tate
хашіл		CENSEE	J .	B. Jenkins	Funeral	Home	
nal Hygiene prior to burial, cremation, or removal y, or other traumatic event, the medical e CERTIFICATION	shock, or heart feilure. IMMEDIATE CAUSE (Finel disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events	DUE TO (OR AS A CONSE	DUENCE OF):				Interval Between Onset and Death
ws any inju	PART II. Other significent condition	a contributing to death but not o	aaulting in tha unda	lying cause givan in Par	PERFORMED	NO OF D	LABLE PRIOR TO PLETION OF CAUSE JEATH?
Dept.	25. WAS CASE DEFERRED TO MEDICAL EXAMPLER?	26. PLA	CE OF DEATH (Check only				
with the ked, o	27. MANNER OF DEATH 1 Netural 5 Pending	1 TEST SPORTING 1 DIRECTION 1 TEST SAIDE					
8 is n	3 Suicide 6 Could not be	26e. PLACE OF INJURY — At he building, etc. (Specify)	me, farm, atreet, factory,	offics 28		Number or Rural Route I	Number,
2 = 5	(Check only						manner as stated.
PORT BE	August XX	O COMPLETIO CAUSICOF DEATH JITE	M 27) (Type, Print)	D LICENSE NUMBE	0	Nous Signed Month	th. Day, Year) 92/199
0)	Audusto P. Ko.	drikuzNW.	0019 Kg	es Bureal YL	Ca Sua	1/12 70	7116

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

IF UNDER 1 YEAR IF UNDER 24 HRS.

HOURS

9b. CITY, TOWN OR LOCATION OF DEATH

DAYS

7. DATE OF BIRTH (Month, Day, Year April 1

12

38

9c. COUNTY OF DEATH

enable

6. AGE (In yrs. lest birthday)

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

Pages 1, 2, 3 should permit. Page 6 may be retained by the hospital or attending physician. all director, page 5 should be detached for use as the burial-transit signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for Heath and Mental Hygiene prior to burlal, cremation, or removal. notified at 9 must examiner hours after death. medical the other traumatic event, 0 any Injury, ORECTOR: After this certificate has been signs hours after death with the State Dept. of Heat item 28 is marked, or item 23 shows OR ATTENDING PHYSICIAN: The law FUNERAL within 72 h HOSPITAL TO THE HOSPITA
TO THE FUNERA
De filed within 7.

Dr. Fear	0									9	5	38 027
1 - FOR STATE REGISTRAR		STATE OF I	MARYLAND / CE	DEPAR RTIF	TMEN ICATI	T OF H	DEA	AND TH	MENTAL HYGIEN REG. NO.	E		
1. DECEDENT'S NAME (Firs	Hell	en Ire	ne		We	ber			2. DATE OF DEATH MONTH 29 DA	1995	YEAR	3. TIME OF DEATH 1030 A
4. SOCIAL SECURITY NUM 220 16 79		5. SEX	8. AGE (In yrs. lest	birthdey) YRS.	IF UNDER	DAYS	IF UNDER	MIN.	7. DATE OF BIRTH MAMON, 27 16 92	4	8. BIRTNPLACE (State or Foreign Country) Maryland	
9a. FACILITY NAME (If not I 1015 DOMSEY R		treet and number)					ederi.		EATN	calv	UNTY OF C	
RESIDENCE OF DE	CEDENT											
Maryland	Calvert				y, town o		erick					10d. INSIDE CITY LIMITS? 1 YES 2 XNO
104. STREET AND NUMBER 1015 DOKSEY I							20678	E			rizen of v	WHAT COUNTRY? ates
11. MARITAL STATUS		12. WAS DECEDEN	T EVER IN U.S. ARM	(ED	12	WAS DEC	ENDENT (NE MISDA	HC OBIOINS (Co.o. N. V.		T 44 040	

4. SOCIAL 220 9a. FACILIT DIRECTOR 1015 RESIDE 10a. STATE Maryla 10e. STREE FUNERAL 1015 11. MARITA FDRCES? 1 YES 2 NO Black, White, etc. If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married IF YES, GIVE WAR DR DATES 3 Widowed 4 Divorced 1 TES 2X NO specifichite BY Specify: ETED 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16b. KIND OF BUSINESS/INDUSTRY (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) COMPL 12 housewife own hame 17. FATNER'S NAME (First, Middle, Last)
James Johnson King 18. MOTHER'S NAME (First, Middle, Melden Surname)
Pearl Ethel Buck BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILIND ACORESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 0 Karl Weber 95 Dorsey Rd. Prince Frederick Maryland 20678 20s. METHOD OF DISPOSITION
\$\(\) Burlel 2 \quad \text{Cremation 3 } \quad \text{Removal from State} \\
4 \quad \text{Donation 5 } \quad \text{Other (Specify)} \] 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, Stata Pauls Fois. Church Cemetery rince Frederick Cal. Maryland 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY RAISCH FUNERAL HOTE P.A. 4405 Broomes is. Rd. Port Republic Maryland 20676 23. PART I. Enter the diseases, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, Approximata shock, or heart failure. List only one cause on each line. interval Between **IMMEDIATE CAUSE (Final Onset and Death** disease or condition mobable vontricular avolythmia musicos resulting in death) romany arteny de CERTIFICATION Sequentially list conditions, DUE TO (DR AS A CONSEDUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEDUENCE OF) that initiated events resulting in death) LAST PART II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. MEDICAL 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS PERFORMED? AVAILABLE PRIOR TO aneurysms-COMPLETION OF CAUSE 1 TYES 2 ND DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 28. PLACE OF DEATN (Check only one) HOSPITAL: OTHER: 1 YES 2 TND 1 | Inpatient 2 | ER/Outpatient 3 | DOA ng Nome 5 Residence 8 Other (Specify) 27. MANNER OF DEATH 28a. DATE OF INJURY 28c, INJURY AT 28b. TIME OF INJURY 28d. DESCRIBE NOW INJURY OCCURED 1 Netural 1 YES 2 ND м BY 2 Accident 28e. PLACE OF INJURY — Al home, larm, street, factory, offica building, atc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Sulcide COMPLETED 6 Could not be 4 Homicide 29a. CERTIFIER

1 CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and menner as stated. 2 MEDICAL EXAMINER: Dn tha of examination anglor investigation, in my opinion, death occured at the time, data and place, and due to the cause(s) and menner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d, DATE SIGNED (Month, Day, Year) BE

_	9 00/000	2		
30.	NAME AND ADDRESS OF PERSON WHO	COMPLETEO CAUSE	OF DEATH (ITEM	27) (Type, Print)
	I. FROCE	Fears	120	HOSA

NOV 3 0 1995

Fears

32. REGISTRAR'S SIGNATURE · Savelson Rardall

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

31. DATE FILED (Morith, Day, Year)
DEC 0 5 1995

32. REGISTRAR'S SIGNATURE
Julia Shuelon Randall

	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the human anctor, page 5 should be detached for use as the burial-transit permit. Pages 1.		
ter tolling proportional.	as the burial-tran		
TISICIAN THE IMPRINES WAS USED FOR LOCATE OF EXCLUSION WHITE IT TOUR TO THE IMPRINES OF TRANSPORTED OF STREETING OF STREETING	detached for use		9000
y or recalled by	sage 5 should be		he notified at
Manual Page O IIIa	funeral director, p		IMPORTANT: If New 28 is marked or item 23 shows any injury, or other traumatic event, the median examiner must be notified at eace
E TIONE EIDON FE	y filled in by the	tion, or impossi.	the medical a
c cycolica within	an and completel	r to burial, crema	umafic event
ממחו רבו חוורמנב ח	attending physici	ntal Hygiene prio	v or other tra
מחוובם ווימו חוב ח	n signed by the	f Health and Me	nowe any injur
ICINIA 1115 Idw II	ertificate has bee	the State Dept. c	or item 23 e
LENDING PRIS	TOR: After this c	after death with	28 ie markad
IO INE MUSICIAL UN A	FUNERAL DIREC	within 72 hours	TAMT: If item
IN INE	TO THE	be filed	MPOR

FOR STATE REGISTRAR	·····	STATE OF I	MARYL					IEALTH DEAT		MENTAL HYGIEN REG. NO	_		
1. DECEDENT'S NAME (First		Beatrice	A.	Wyvi	11					NOV 30,19	95	YEAR	3. TIME OF DEATH 4:30 P M
4. SOCIAL SECURITY NUMBER 220-38-395		5. SEX	6. AGE (in yrs. lest birth		UNDER 1 Y	EAR AYB	IF UNDER	24 HRS. MIN.	7. DATE OF BIRTH JULY 9, 1	909	8. BIRTH	PLACE (State or Foreign
		••		91 "									
9e. FACILITY NAME (If not in								OR LOCATIO		EATH		INTY OF D	
Manor Care N		g Center				uppe	r	Marlk	oro		PLL	nce (George's
10e. STATE	10b. COUNTY	r		100	CITY, TO	WN OR I	OCAT	TION					10d. INSIDE CITY
Maryland	Princ	ce George	e's	Į	Jppe:	r Ma	rl	boro					LIMITS?
10e. STREET AND NUMBER							101	f. ZIP CODE			10g. CIT	IZEN OF	WHAT COUNTRY?
15807 Mar.	lboro 1	Pike						2077	72		Uni	ted :	States
11. MARITAL STATUS		12. WAS DECEDEN	T EVER II	N U.S. ARMED		13. WAS	DEC	CENDENT O	F HISPAN	NIC ORIGIN? (Specify Yes	or No-	14. RAC	E — American Indian,
1 Never Married 2		FORCES? 1				If ye	YES	ecify Cuber	n, Mexica Specifi	in, Puerto Rican, etc.)		Spec	k, White, etc.
3 M Widowed 4 □ Divorced White													
	EOENT'S EDU			16e. DECEDE	NT'S USU	IAL OCCL	JPAT (C	ON ost of workin	a	166. KIND OF BU	SINESS/IN	DUSTRY	
Elementary/Secondary (I	-	College (1-4 or 5	+)	life. Do N	OT use ret	tired.)	ng mo	or worm	v				
10th				House	wife					Home			
17. FATHER'S NAME (First, M	fiddle, Last)							18. MOTH	IER'S NA	ME (First, Middle, Meiden	Sumeme)		
Albert W. V	Wells							Luc	y A	nn Taylor			
190. INFORMANT'S NAME (Type/Print)			19b. MA	ILING ADD	DRESS (S	treet e	and Number	or Rural	Route Number, City or Tow	n, State, Zi	p Code)	
Donald J. W	vvi11	(Son)		158	07 M	arlb	or	o Pil	ce.	Upper Marl	boro	, Md	20772
20e. METHOO OF OISPOSIT 1 X Burlel 2 Cremetic 4 Donation 5 Other 21 SIGNATURE OF URE PA	on 3 Rem		20b cen Mr	PLACE AND D netery, cremator Ount C	y or other p	i Ce	me	tery		Upp Courtee Fune	er M	arlb	oro, Marylar
Josep	11	EX.	St	_		010	l A	lexar	ndri	a Ferry Ro	ad,	Clin	ton, Md 20735
23. PARTA. Enter the d ahock, or h IMMEDIATE CAUSE (Fir disease or condition resulting in death)	eart fallure.	e. Co^	use on e	ech line.	VE	-	(-	TEA	R	TRAT			Approximate interval Between Onset and Death
Sequentially list condit if any, leading to imme cause. Enter UNDERLY CAUSE (Disease or Inj that initiated events resulting in death) LAS	ing ury	b. DUE TO	(OR AS A	CONSEQUEN	S (CE OF):			205	15	>			
DID TOBACCO L	YMOT JSE CONT	10 K1 (0	5/3	of DEATH	DE YES	- M	27 5)	YUNC	25	PERFO	RMED?	241	D. WERE AUTOPBY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
25. WAS CASE REFERRED 1 EXAMINER?	O MEDICAL	HOSPITAL:		26. PLACE OF			y oné))					
1 TES 2 NO		1 Inpatient 2	ER/Out	patient 3 🗆 D		HER: Nursing	9 Hon	ne 5 🗆 Re	eldence	6 Other (Specify)			
27. MANNER OF DEATH Notural 5	Pending	28e. DATE OF		280	. TIME OF		WC	JURY AT ORK? YES 2	7 MO	28d. DESCRIBE HOW	INJURY O	CCURED	
Accident 3 Suicide 8 4 Homicide	Investigation Could not be determined	28e. PLACE (building	OF INJURY	/ — At home, t	erm, stree				_ 110	281. LOCATION (Street City or Town, State		or Aural	Route Number,
onel .										to the couse(e) and me			e) end manner ee stated.
29b. SIGNATURE AND TITLE	all	Xor	^	10				29c. LICI	2	MBER 94	29d. DA	TE SIGNE	0 (Month, Day, Year) -01-45
30. NAME AND ADDRESS O							- 7	77		Manalla	M. J. O.	0770	
Michael F.	York,	MD. 5506	Gre	en Lar	nding	g Ro	ad	, Upp	er l	Mariboro,	Md 20	0//2	

	FOR STATE REGISTRAR	STATE	0F	MARYLAND		DEPARTM
_			_		_	

ENT OF HEALTH AND MENTAL HYGIENE ATE OF DEATH REG. NO.

	1. DECEDENT'S NAME (First,	Middle, Lesti								2. DATE O	OF DEATH			3. TIME OF DEATH	
			and law are		_	0				MONTH	Di	41	YEAR		
	Richard 4. SOCIAL SECURITY NUMB		s. SEX	8. AGE (In yrs. I	nzel	Sr.		IF UNDE	2 44 1000	Nover	-	9, 1	995	4:46 p M IPLACE (State or Foreign	
	214-18-95		1 XM 2 F	74	YRS.	MONTHS	DAYS	HOURS	MIN.	Apr	Dey 9'001) 1	.921	Count	(Y)	
	9a. FACILITY NAME (If not in	stitution, give s	treet and number)			9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DE						DEATN			
5	Frederick M		1 Hospit	al			Fred	leric	k			Fr	Frederick		
2	RESIDENCE OF DEC	10b. COUNT	Υ		10c, CIT	Y, TOWN	OR LOCA	TION						10d, INSIDE CITY	
	Md.	341	Frederic	k			deri							LIMITS?	
2	10e, STREET AND NUMBER						10	. ZIP COD	E			10g. CIT	IZEN OF	WHAT COUNTRY?	
	915 Seminol	e Rd.						2	21701			U.S	.A.		
5	11. MARITAL STATUS		12. WAS DECEDEN								? (Specify Ver	or No-	14. RAC	E — American Indian,	
-	1 Never Merried 2 3 Wildowed 4 Divo		IF YES, GIVE	YES 2 X	ÎNO			2 X NO		nn, Puerto R ly:	lican, atc.)	Black, White, atc. Social White			
3		EDENT'S EDU			DECEDENT'S					16b.	KIND OF BU	SINESS/IN	DUSTRY		
	(Specify only Elementary/Secondary (0	ly highest grade	College (1-4 or 5		(Give kind of life. Do NOT u	work done se retired.)	during me	ost of work	ing						
	11	,			ectri	.cal	engi	neer	:	6	electr	cic m	otor	co.	
5	17. FATHER'S NAME (First, M							16. MOT	NER'S NA	AME (First, N	fiddle, Maiden	Surname)			
)	Frederic	k Wenz	el .					Ma	abe1	Unkno	OWN				
7	190. INFORMANT'S NAME (er, City or Tow				
	Richard A.	Wenzel	Jr.		8613D	Fal	ls F	Run F	₹d.,	Ellic				21043	
	20a, METNOD OF DISPOSIT	on 3 🗌 Rem	noval from State	cemetery,	E AND DATE	other place,)			DATE	100			own, State	
	4 Donation 5 Other		CENSEE	Luth	eran	Ceme	tery	ND ADDR	E99 AE E/	12/	2 Mic	dlet	own,	Md.	
	the 0.0	5/Du	orton								n Fune				
	Vis-Gu		0.17								iddlet				
	23. PART I. Enter the dehock, or h IMMEDIATE CAUSE (Fir disease or condition resulting in death)	neart fallure. nel	a. Ven	use on eech II	na.						nac or resp	iratory a	rest,	Approximate Interval Batween Onset and Daath	
	Treating in Geen,		DUE TO	OR AS A CON	SEQUENCE C	OF):					^	,	4.00		
	Sequentially list condit	tions.	. Acu	O (OR AS A CONS (OR AS A CONS	ferio	- Y	nyo	car	die	(]	Inta	-rct	ion	8 hrs	
	If any, leading to imme	diate	DOE IC	O (OH AS A CONS	A SECUENCE)F):	-	70.						11. Kanus	
3	CAUSE (Disease or Inju		c. Cor	O A GON	SEQUENCE C	PR:	7	13	eas	-				UNKNOWY	
	that initiated events resulting in death) LAS	ВТ .	_	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,											
2			d												
4	PART II. Other algnifica	ant conditio	na contributing to	deeth but no	t resulting	In the u	nderlylr	g cause	given in	Part I.	24a. WAS AP PERFO		24	b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO	
2				<u>_</u>							1 YES	X NO		COMPLETION OF CAUSE OF DEATH?	
														1 TYES 2 NO	
	DID TOBACCO U	JSE CONT	RIBUTE TO CA	AUSE OF DE	ATH Y	ES 🗆	NO E	UN	CERTAI	N 🗆					
2	25. WAS CASE REFERRED T	TO MEDICAL		26. Pt	ACE OF DE)							
0	EXAMINER?		HOSPITAL:	ER/Outpatient	3 🗆 DOA	OTHE		ne 5 🗆 F	Rasidence	8 🗆 Othe	r (Specify)				
rut sician.	27. MANNER OF DEATH		28a. DATE O	F INJURY Day, Year)	28b, TII	ME OF	28c. IN	JURY AT	UIA	28d. DES	CRIBE NOW	INJURY O	CURED		
	1 Natural 5 2 Accident	Pending Investigation	N		N			YES 2		/	NIA				
	3 Suicide 6	Could not be	28a. PLACE building	OF INJURY — At	home, farm,	street, ta	ctory, offi	ca		281, LOC	ATION (Street or Town, State	and Numb	or Rural	Route Number,	
29s. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated.															
3				availmilation and	or anvestigat	ion, in my	ориноп,	death occ	area at In	e time, date	and prace, a				
IJ.	296, SIGNATURE AND TITLE	E OF CERTIFIE	ER	mr					CENSE NU			29d. DA	TE SIGNE	D (Month, Day, Year)	
2	Moder	W.	Ley	1110				D	473	47			111:	29/95	
-	30. NAME AND ADDRESS O	F PERSON W	Leva,		mD	e, Print)	119	th s	54	Fred	Periol	- m	Da.	170/	
	31. DATE FILED (Month, Day,	, Year)		IAR'S SIGNATUR	E	1.00			-	1 / 20		1	6-1	.01	
	Michael W. Levangie. MD 310 W.9th St., Frederick, MD21701 31. DATE FILED (MORTH, Day, 1901) 11/129195 DEC 0 1 1995 Shuden Revolution														

857 . .

TTEMS: 23 PART I. 27. PER MEO ETLM G-730 12/20/95 + +

	FOR 1 - STATE REGISTRAR		MARYLAND /	DEPAR		HEALTH	AND	MENTA	L HYGIEN			1
	1. DECEDENT'S NAME (First, Middle, Last)								OF DEATH			3. TIME OF DEATN
	MARY ELIZ	ZABETH	W.	ALSI	H			NOV			YEAR	0852 A M
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. last	birthday)	IF UNDER 1 YEAR	IF UNDER		7. DATE	OF BIRTN		-	IPLACE (State or Foreign
- 1	216-58-9719	1 - M 2 - F	43	YRS.	MONTHS DAYS	HOURS	MIN.	March	23,	1952		ington, D.C
	9s. FACILITY NAME (If not institution, give a				9b. CITY, TOWN		ON OF D			9c. COUN	ITY OF D	EATH
FUNERAL DIRECTOR	4507 GREEN VAI	LEY RO	AD		MONR	AIVC				FRI	EDEF	RICK
ᇤ	RESIDENCE OF DECEDENT 10s. STATE 10b. COUNT	Y		t0c. CIT	Y, TOWN OR LOC	TION						10d. INSIDE CITY
E	Marvland Frede	rick			ovia							LIMITS?
4	10e. STREET AND NUMBER	TICK		LIOILL		t. ZIP COD	E			10g. CITI	ZEN OF V	WHAT COUNTRY?
ER/	4507 Green Valley	Road				2177	0			Uni	ted	States
3	11, MARITAL STATUS	12. WAS DECEDEN	IT EVER IN U.S. ARN	AED		CENDENT (OF NISPA		I? (Specify Yes			E — American Indian, k, White, etc.
BY F	1 Never Merried 2 Merried 3 Widowed 4 Divorced	IF YES, OIVE V	YES 2 NO	0		S 24 NO		en, Puerto lly:	Rican, etc.)		Spec	
												White
COMPLETED	15. DECEDENT'S EDU (Specify only highest grade	CATION completed)	(Giv		WORK done during it		ing	16b	. KIND OF BU	SINESS/IND	USTRY	
빌	Elementary/Secondary (0-12)	College (1-4 or 5	+)									
N N	1.2 17. FATNER'S NAME (First, Middle, Last)		CIE	rica	1 Worke	_	NEDIO N		ortgag Middle, Melden			
	James Arthur Wa	lah Cr				Ze1			abeth		h	
BE	190. INFORMANT'S NAME (Type/Print)	isii, si.	196.	MAILING	ADDRESS (Street		_					
임	Zelma E. Stager				reen Va						217	70
- 11	29e METHOD OF DISPOSITION 1 Burlet 2 Cremetion 3 Rem				OF DISPOSITION (1101		E 20c. LO			
	Buriet 2 Cremetion 3 Rem	oval from State	cemetery cren	natory or o								Maryland
	21. SIGNATURE OF FUNERAL SERVICE LE	CENSEE	, ,		22. NAME	ND ADDRE	SS OF F	ACILITY				
	>16-P	RMO	- Kan	7					lomes,		-1 - 1-	MD 01700
	23. PART I. Entar the diseases, or	complications the	at caused the det	ath. Do i								, MD 21702
	ahock, or heart fellure. iMMEDIATE CAUSE (Finel	Liet only one cer	use on each line.			,					-	intervel Between Onset and Death
	disease or condition Hypertenetic Aptrology EDOTTO CARDITONACON AD DICEACE											
	resulting in death) ATTERIENSIVE ARTERIUSCLERUIT CARDIUVASCULAR DISEASE DUE TO (OR AS A CONSEQUENCE OF):											
z		b.										
윤	Sequentially list conditions, if any, leeding to immediate	DUE TO	(OR AS A CONSEQ	UENCE O	F):							
2	cause. Enter UNDERLYING CAUSE (Disease or Injury	c										
ᄩ	that initiated events	DUE TO	(OR AS A CONSEQ	UENCE O	F):							
CERTIFICATION		d										
4	PART ii. Other aignificant condition	ns contributing to	deeth but not re	eaulting	in the underly	ng ceuse	given ir	n Part i.	24a. WAS AN		246	. WERE AUTOPSY FINDINGS
EDIC/									1 YES	11011001		AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
MEC									1			YES 2 NO
ż	DID TOBACCO USE CONT	RIBUTE TO CA	USE OF DEAT	TH YI	S NO	□ UNG	CERTA	IN 🗆				
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLAC	E OF DEA	TN (Check only on)						
YSI	1XXES 2 □ NO		ER/Outpatient 3	□ DOA	OTHER: 4 - Nursing No	me XX	lesidence	6 🗆 Oth	or (Specify)			
PH	27. MANNER OF DEATN 1 Natural 5 Pending	26e. DATE OF (Month, L		28b. TIN	JURY V	JURY AT		26d. DE	SCRIBE NOW	INJURY OC	CURED	
BY	2 Accident Investigation					YES 2	NO NO					
E	3 Suicide 6 Could not be 4 Homicide determined		OF INJURY — At hor , stc. (Specify)	ne, term,	street, tactory, of	Ice			ATION (Street or Town, State		or Rural	Route Number,
	29e. CERTIFIER		-									
COMPLET	(Check only 1 CERTIFYING PHYS	SICIAN: To the best o										
8		-	exemination and/or li	nveatigatio	on, in my opinion	death occu	ared at the	e time, date	and place, er	nd dus to th	e cause(s) and manner as stated.
BE (296. SECRETURE AND TITLE OF CERTIFIE	R /	$(\Lambda \Lambda \Lambda)$)			C . M			29d. DAT	E SIGNED	29, 1995
인	30 NAME AND ADDRESS OF PERSON WI	HO COMPLETED OF		4 9 70 /T	Chief		J . 1 1					,
	Z (A /) \ \ /	SCIL J.	DEATH (ITEN	Pen:	n Stre	et,	Bal	timo	re, M	lary.	land	1 21201
	31. DATE FILED (Month, Day, Year)	CE W	ν			_			-			
	חבר: 0 4 199!	5	Mucleon R	ardall								

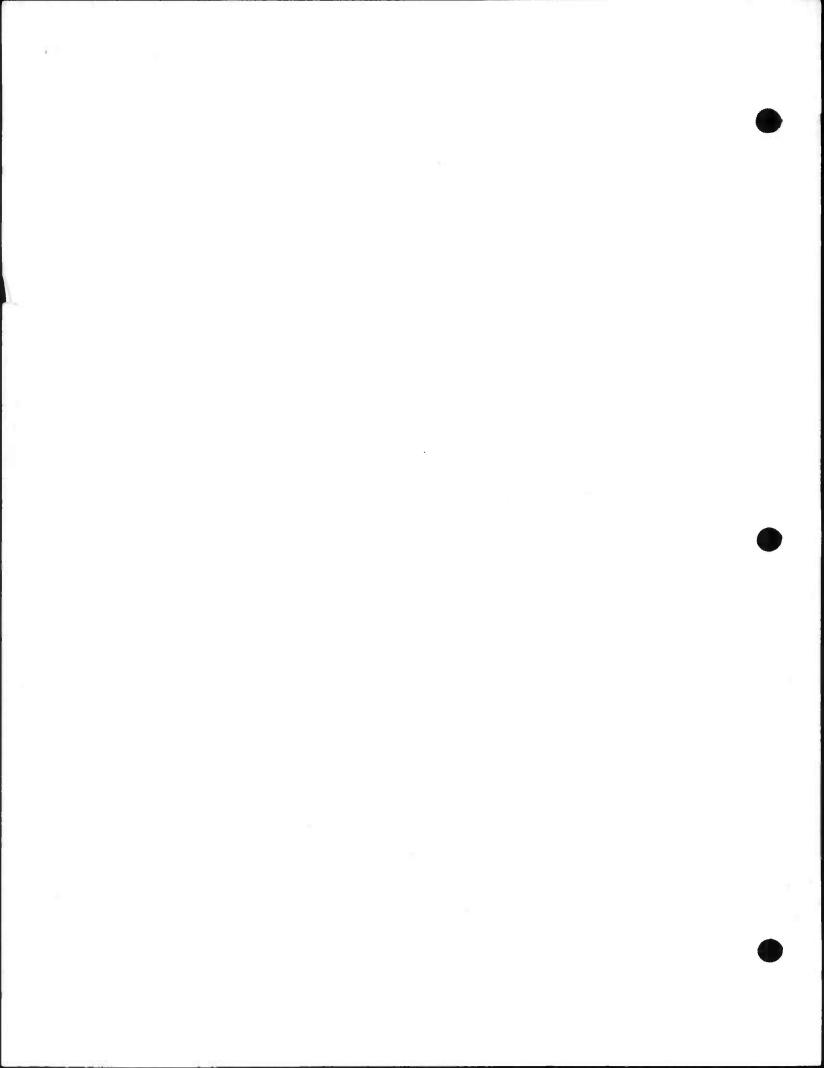
TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 6876

1 - FOR STATE REGISTRAR

		1 - FOR STATE REGISTRAR	STATE OF MARYLA	ND / DEPAR	TMENT OF	HEALTH AND	MENTA	HYGIEN	E		
		1. DECEDENT'S NAME (First, Middle, Last)	Mary Ellen Wa	arehime			2. DATE MONTH Dec	OF DEATH	199	EAR	TIME OF DEATH
		4. SOCIAL SECURITY NUMBER		yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE	OF BIRTH		BIRTHPLA	II: 15 a MCE (State or Foreign
pino		219-20-0602 9a. FACILITY NAME (If not institution, give str		69 YRS.	MONTHS DAYS	HOURS MIN.	Sept	. 21,1	926	Country)	aryland
2, 3 should	ЕСТОВ	410 Oakhill Ct.,				ninster	CAIN		ec count	roll	n.
Pages 1,	EC	10a. STATE 10b. COUNTY		10c. CIT	Y, TOWN OR LOC	ATION				104	d. INSIDE CITY
permit. Paq	L DIR	Maryland C	arroll	We	estmins	ter					LIMITS?
	FUNERAL	410 Oakhill Ct.,	Ant T-/		,	2115	7				States
020 physician burial-tran	S	11. MARITAL STATUS	12. WAS DECEDENT EVER IN	U.S. ARMED	13. WAS DE	ECENDENT OF HISPA	NIC ORIGIN	? (Specify Yea		RACE -	American Indian.
215-0020 attending physician. ise as the burial-transit	B	1 Never Married 2 Married 3 Widowed 4 Divorced	FORCES? 1 YES	EST		specify Cuban, Maxic ES 2 NO Speci		lican, etc.)		Black, W Specify:	White
S # 2	TED	15. DECEDENT'S EDUCA (Specify only highest grade of	ATION ompleted)	(Give kind of a	Sa. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired,)						
0 - 5	COMPLET	Elementary/Secondary (0-12)	Coffege (1-4 or 5+)		_			G C D	m 1	,	
S de P	MO	17. FATHER'S NAME (First, Middle, Lest)			Worker	18. MOTHER'S NA	ME (First, A		Teler	hone	
8 8 E	w	Ge	orge Washing	ton Law	rence		Par	ıline	Utz		
MAR retained 5 should notified	10 B	19a. INFORMANT'S NAME (Type/Print)		19b. MAILING	ADDRESS (Street	t and Number or Rural	Route Numb	er, City or Town	, State, Zip Co	de)	Md
т 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2		HO 20a, METHOD OF DISPOSITION	mer Warehime	410	0 Oakhi	11 Ct., A				ster	,21157
Ctor.		1 T Burial 2 Cremation 3 Ramov	rel from State camer	tery cremetory or o	ther place)	Dec 6	1995		estmir		
		21. SIGNATURE OF FUNERAL SERVICE		adow bro		AND ADDRESS OF FA	CILITY				<u> </u>
ALTIN death. Pag e funeral di if.		Mark A.	t-		41	2 Washino					& Chapel ,Md 21157
hours after of the ln by the or removal.		23. PART I. Enter the diseases, or co	mplications that caused	the daeth. Do n	not enter the m	node of dying, suc	h as card	lec or respli	ratory arres	l,	Approximata
y filled in b tition, or ren		shock, or heart fellure. Li IMMEDIATE CAUSE (Final	let only one cause on eac								Interval Between Onset and Death
= = I		disease or condition resulting in death)	- Janer		Cone	v					4mo
	_		OUE TO (OR AS A C	CONSEQUENCE OF	F):						
×	CATION	Sequentially list conditions, if any, leading to immediate	OUE TO (OR AS A C	CONSEQUENCE OF	F):						
cate be physician e prior	S	CAUSE (Disease or Injury									
h certificate anding physical Hygiene pro	RTIFIC	that initiated events resulting in death) LAST	DUE TO (OR AS A C	F):							
deat deat de attr femtal	낑	DARW II Oshor elevitions on this									
I # 6 # >	MEDICAL	PART II. Other eignificant conditione	Contributing to death but	not resulting		ng cause given in	Part I.	24a. WAS AN / PERFOR		AM	RE AUTOPSY FINDINGS VILABLE PRIOR TO
S E E E	ED		0	Fun	200		-	1 TYES 2	NO	OF	MPLETION OF CAUSE DEATH?
Sh of Sh		DID TOBACCO USE CONTRI	BUTE TO CAUSE OF	DEATH YE	S NO E	UNCERTAI	N D			1 1	YES 2 NO
en ate h	SICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26 HOSPITAL:	B. PLACE OF DEAT		9)					
SICIAN: The certificate the State is the Sta	IYSI		1 Inpatient 2 ER/Output			me 5 Residence					
F Signature	/ PHY	1 Netural 5 Pending	28a. OATE OF INJURY (Month, Day, Year)	28b. TIM	URY W	JURY AT /ORK? YES 2 NO	28d. DE\$	CRIBE HOW IN	JURY OCCUR	ED	
NDING Heath Is man	D BY	2 Accident investigation 3 Suicide 8 Could not be	28e. PLACE OF INJURY building, etc. (Specify	- At home, farm, s		1 - 11	28t, LOC/	TION (Street a	nd Number or	Rural Route	Number,
DR ATTENDING PHYSICIAN: DIRECTOR: After this certifica hours after death with the St tem 28 Is marked, or it	ETED	4 Homicide determined	bunding, etc. (Specify	"			City o	r Town, State)			
4 4 2 E	COMPLET		AN: To the best of my knowled								
TO THE HOSPITAL TO THE FUNERAL De filed within 72 IMPORTANT: If	Ö	2 MEDICAL EXAMINER:	On the basis of examination a	and/or investigatio	n, in my opinion,	death occured at the	time, date	and place, and	dua to the c	euse(a) and	d manner as stated.
THE F	BE	29b. SGNATURE AND TITLE OF CERTIFIED	the			29c. LICENSE NUI	MBER		29d. DATE S	GNED (Mo	nth, Day, Year)
P P 2 Z	2	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED PAUSE OF DEAT	H (ITEM 27) (Type	Print	127	77		12	. 5	7-
		688 Pool	e Road	· W	estron	usla	m	nl	211	57	-
		JEU 5 1995	32. REGISTRAR'S SIGNAT	Kardall							

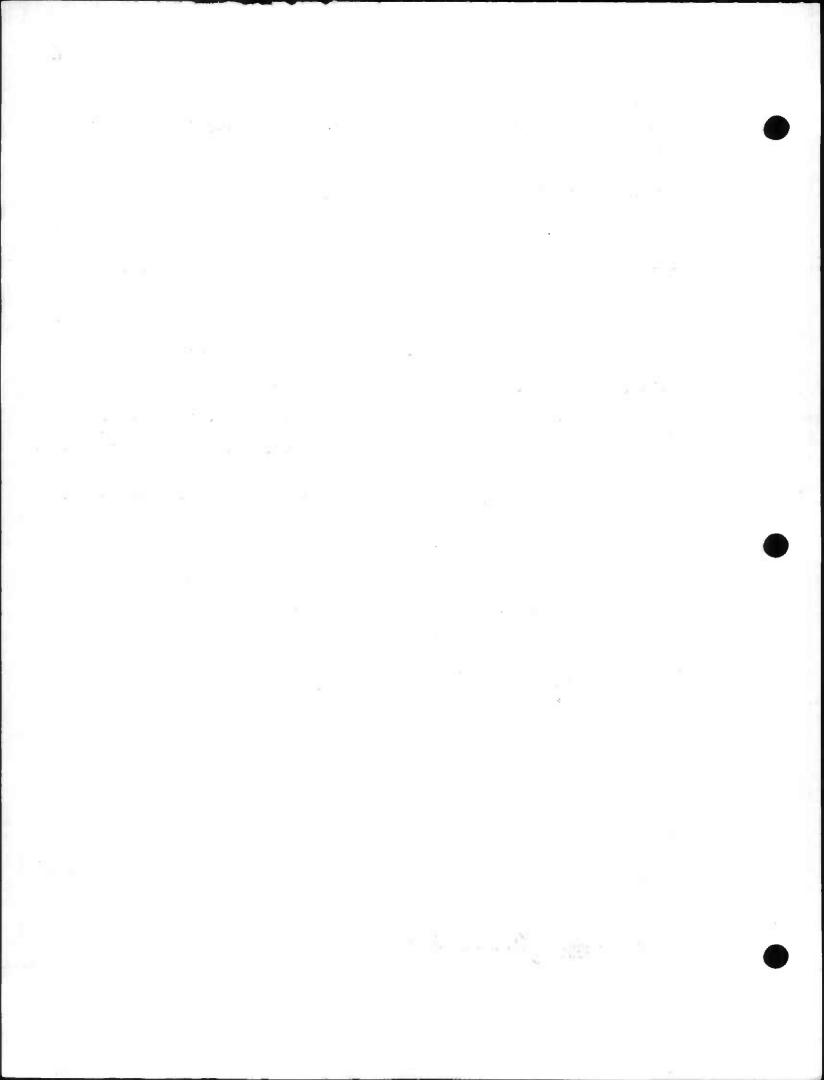


be retained by the hospital or attending physician. BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

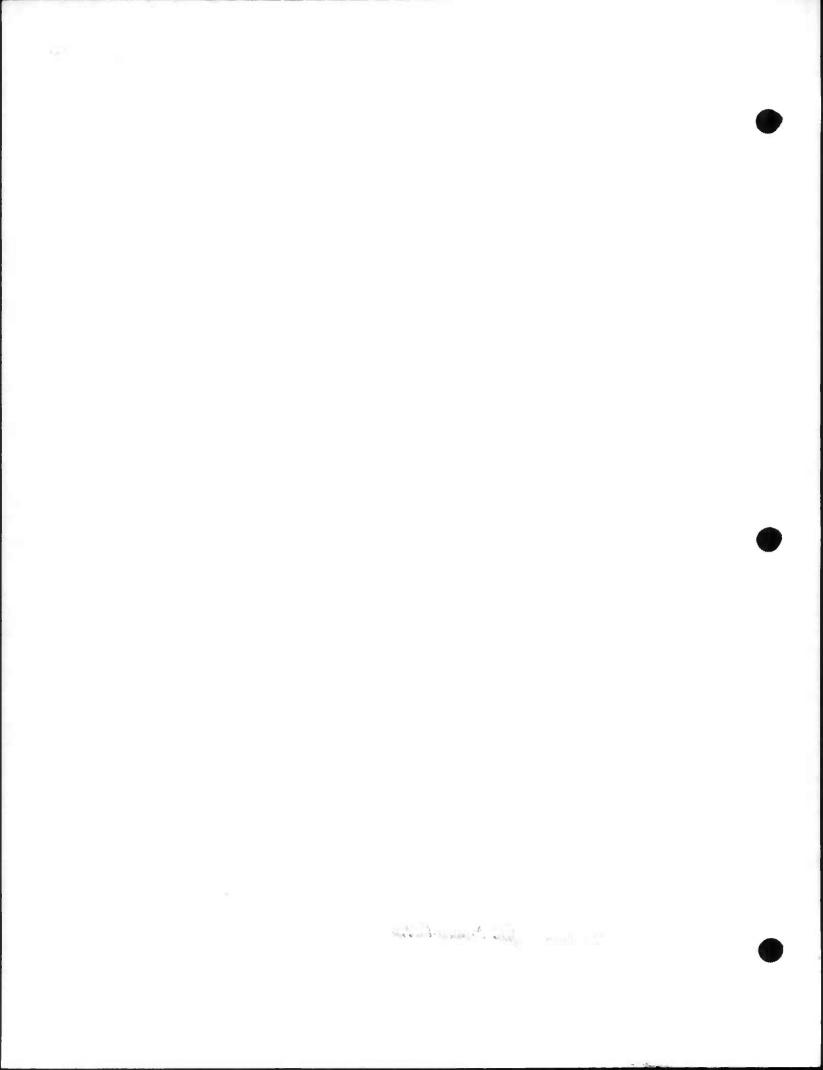
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TAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 ho	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled	be filed within 72 hours after death with the State Dept. of Health and Mental Hyglene prior to burial, cremation, or removal.	It item 28 is marked, or item 23 shows any injury, or other traumatic event, the m
TO THE HOSPI	TO THE FUNER	be filed within	IMPORTANT :

	FOR 1 - STATE REGISTRAR	STATE OF MARYL			F HEALTH AND I	MENTAL HYGIENE			
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF OEATH		3. TIME OF DEATH	
	Cecelia	М.		Wash	ington	November 22,	1995	10:40 A M	
		HILLS CONTRACTOR	In yrs. lest birthday)	IF UNDER 1 YE		7. DATE OF BIRTH (Month, Day, Year)	8. BIRT	HPLACE (State or Foreign	
	213-54-8941 1	□ M 2 🔀 F 76	YRS.			7/28/19		ÿland	
œ					WN OR LOCATION OF DI	ATH	9c. COUNTY OF		
DIRECTOR	Physicians Memorial Ho	spital		La	Plata	Char.	les		
SE SE	10s. STATE 10b. COUNTY	-		, TOWN OR L	CATION		10d. INSIDE CITY LIMITS?		
	MD Charle	S	LaP.	lata				¥∏ YES 2 ☐ NO	
FUNERAL	10e. STREET AND NUMBER	han Dd			101. ZIP CODE 20616			WHAT COUNTRY?	
NE	P.O. Box 51 Brya		ALLIE ARMED	42.480		US ODIONIS (F H. V	U.S.	A . CE — American Indian,	
BY FU	11. MARITAL STATUS 1 Never Married 2 Married 1 Never Married 2 Married 3 Widowed 4 Divorced 12. WAS DECEDENT EVER IN U.S. ABMED FORCES? 1 YES 2 NO If yes, specify Cuben, Maxican, Puerto Rican, atc.) 14. RACE — Black, W Specify: 15. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuben, Maxican, Puerto Rican, atc.) 16. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify: Was December 13. Was December 15. Was December 16. Was December 16								
15. OECEDENT'S EDUCATION (Specify only highest grade completed) 16e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working 16b. KIND OF BUSINESS/INDUSTRY									
COMPLETED		ollege (1-4 or 5+)	Iffe. Do NOT us	e retired.)	g most of working	Designation to			
MPI	8		Homem	aker		Privat	.e		
S	17. FATHER'S NAME (First, Middle, Last)	l no				ME (First, Middle, Meiden S lie Bowma			
BE	William Dyson S 190. INFORMANT'S NAME (Type/Print)	• 10							
2	Thelma Florence		8030	Marsh	all Corn	Route Number, City or Town, or Rd. Pom	fret, M	d.20675	
	20e, METHOD OF OISPOSITION 1	from State 20b	PLACE AND DATES	r dispositio	Meth Ch.	Cem. 11/27	ATION — City or 1	onkey, MD.	
	21. SIGNATURE OF UNERAL SERVICE LICENS	411		22. NAN	E AND ADDRESS OF FA	CILITY Hodges	and E	dwards	
	Il sout t	todel		207	0 6:100	Hill Rd.	Cui+1-	OM ba	
_	23. PART I. Enter the diseases, or com	plications that cause	the death. Do n					Approximate	
	shock, or head/failure. List iMMEDIATE CAUSE (Fine)	only one cause on e	ach line.			^		Interval Setween Onset and Death	
	disease or condition resulting in death) a. Corontry artery disease DUE TO (OR AS A CONSEQUENCE/OF): Corontry artery disease DUE TO (OR AS A CONSEQUENCE/OF):								
z		arter	bose	len	e rer				
CERTIFICATION		DUE TO (OR AS A							
2	CHOOL (Discose of Hillian)	Nico-ca-	CONSEQUENCE OF	1	1-019 10	7			
E	that initiated eventa resulting in dasth) LAST	archi		j.				i l	
CE	d			7.7					
AL.	PART II. Other algnificant conditions of	ontributing to deeth b				Part i. 24s. WAS AN A PERFORI		b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO	
MEDIC	allengal receive	7 / 1		1	the year	1 TES 2	Signo	OF DEATH?	
	corenvase	ler a	ecide.	7-0	Trision			1 TYES 2 NO	
PHYSICIAN:	DID TOBACCO USE CONTRIB		28. PLACE OF DEAT			иПТ			
S	EXAMINER?	OSPITAL:		OTHER:					
HYS	27. MANNER OF DEATH	Inpetient 2 ER/Outp	28b. TIM		Home 5 Residence	8 U Other (Specify) 28d. DESCRIBE HOW IN	LIURY OCCURED		
	1 Natural 5 Pending	(Month, Day, Year)		URY	WORK?				
) BY	2 Accident Investigation 3 Suicida 8 Could not be	28a. PLACE OF INJURY	- At home, farm, I	straet, tactory,	office	281. LOCATION (Street as	nd Number or Rura	l Route Number,	
TED	4 Homicide detarmined	building, atc. (Spec	спу)			City or Town, State)			
29a. CERTIFIER (Check only one) 29a. MEDICAL EXAMINER: On the basis of azamination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and menner as stated. 2 MEDICAL EXAMINER: On the basis of azamination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and menner as stated.									
SO	MEDICAL EXAMINER: C	On the basis of examination	n and/or investigation	n, in my opini	on, death occured at the	time, data and placa, and	dua to the cause	e(a) and manner as stated.	
BE (29b. SIGNATURE AND TITLE OF CERTIFIER	100	-1 m	20	29c. LICENSE NU		29d, DATE SIGNE	D (Month, Day, Year)	
10	Jane Ja	erel	min	1)	D-08370)	- ///	22/95	
_	Paul Pritchett, MD 118				Plata, Marvl	and 20646			
	31. DATE FILED (Month, Day, Year)	32 REGISTRAR'S SIGN	ATURE						



TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, Page 6 may be retained by the hospital or attending physician,	7 TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept, of Health and Mental Hyglene prior to burial, cremation, or removal.	MPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	
TO THE HOSPITAL OR ATTENDING P	7 TO THE FUNERAL DIRECTOR: After this c be filed within 72 hours after death with	IMPORTANT: If item 28 Is mar	

	1 - FOR REGISTRAR	STATE OF MARYLAN	ID / DEPAR					MENTAL HYGIEN			
	1. DECEOENT'S NAME (First, Middle, Last) Emma E N	leston						2. DATE OF DEATH DOUBLE TO THE TOTAL TO THE TOTAL TO THE TOTAL TO THE TOTAL TO	AY	YEAR	3. TIME OF OEATH
	4. SOCIAL SECURITY NUMBER 5.	SEX 6. AGE (In)	rrs. last birthday)	IF UNDER	R 1 YEAR	IF UNDER	24 HRS.	7. DATE OF BIRTH (Month, Day, Year)		8. BIRTHP	//:50 A M
	220-44-1226 1	M 2 XF 95	YRS.			R LOCATIO		APR.29,1	_	MARY TY OF DEA	
TOR	NATIONAL LUTHER	RAN HOME				VILL				TGOM	
DIRECTOR	MD. 10b. COUNTY MONTO	OMERY CO.		SILV		SPRI	NG				Od. INSIDE CITY LOWITS? VES 2 NO
FUNERAL	11901 – GEORG	SIA AVENUE			101.	101. ZIP CODE 10g. CITIZEN OF WHAT C U. S.A.					
ВУ	11. MARITAL STATUS 12. 1 Never Married 2 Married 3 XWidowed 4 Divorced	WAS DECEDENT EVER IN U. FORCES? 1 YES	2 XNO It yes, specify Cuben, Mexican					en, Puerto Rican, atc.) Ble			- American Indian, White, etc.
ETED	15. DECEOENT'S EDUCATH (Specify only highest grade com		Give kind of life. Do NOT u	work done	during mos	N st of workin	g	16b. KIND OF BU	SINESS/IND	USTRY	
COMPLE	Elementary/Secondary (0-12) Co	ollege (1-4 or 5+)	Hom	,		R		AT.	HOM	石	
	17. FATHER'S NAME (First, Middle, Last) JOHN HENRY	DONCH						ME (First, Middle, Maiden	Surname) ARK		
O BE	19a. INFORMANT'S NAME (Type/Print) REV.DR. REICHAF		19b. MAILING	ADORES	S (Street or	nd Number	or Rural	Route Number, City or Tow	n. State. Zio	Code)	0050
	20a. METHOD OF DISPOSITION	20b. PL	ACE AND DATE				IVE	ROCKVI	CATION —		
	1 Donation 5 Other (Specify)	from State camere		TCOL	N C	EMET		7-11/24-B			
	21. SIONATURE OF FUNERAL SERVICE LICENSEE W. W. HYSONG CO., INC. 1300- N ST., NW, WASH., DC										
	23. PART i. Enter the diseases, or dom shock, or heart fellum. List IMMEDIATE CAUSE (Final	plications that caused the orly one cause on each	ne death. Do i n iine.	not enter	the mod	de of dyi	ng, suc	h as cardiac or resp	iratory arre	eat,	Approximata Interval Between Onset and Death
	disease or condition resulting in death) a. Cerebra Wasculan Acudent 30 days										
z	oue to (or as a consequence of): 5. Mulli Inland Dementia 40 nears										
ATIO	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING	DUE TO (OR AS A CO	NSEQUENCE O	F):	1	Park	6	INDER	./	11.	40 years
CERTIFICATION	CAUSE (Disease or injury that initieted events resulting in death) LAST	DUE TO (OR AS A CO	ONSEQUENCE OF	F):	y	nev	ia	ragen	rec,	[Y 6]	scere!
4	PART ii. Other aignificant conditions co	ontributing to death but		1	-	-		Part I. 24a. WAS AN			/ERE AUTOPSY FINDINGS WAILABLE PRIOR TO
MEDICA	Drounde do	my Hisea	il con	115/	pir	alie	21_	t [] YES 2	NO	0	OMPLETION OF CAUSE F DEATH?
	DID TOBACCO USE CONTRIBI					UNC	ERTAII	N 🗆			YES 2 NO
PHYSICIAN:		26. DSPITAL: Inpatient 2 ER/Outpatie	PLACE OF DEAT	ОТНЕ	FT:	E [] 9-	aldanaa	6 Other (Specify)			
РНУ	27. MANNER OF OEATH 1 X Natural 5 Pending	28e. DATE OF INJURY (Month, Day, Year)	28b. TIM		28c. INJU	JRY AT	BIOGRACIE .	28d. DESCRIBE HOW t	NJURY OCC	URED	
Э ВУ	2 Accident Investigation 3 Suicide 8 Could not be	28s. PLACE OF INJURY —	At home, term,	M street, fact		ES 2 [NO NO	28f. LOCATION (Street)	and Number	or Rural Rou	te Number
ETEL	4 Homicide determined	building, etc. (Specify)						City or Town, State)			
298. CERTIFIER (Check only one) 299. CERTIFIER (Check only one) 290. CERTIFIER (Check only one)										nd menner se stated.	
BE	296. SIGNATURE AND TIPLE OF CENTIFIER	m n	11			29c. LICE	NSE NUR	MBER /	29d. OATE	SIGNED (A	fonth, Day, Year)
5	30. NAME AND ADDRESS OF PERSON WHO CO	MPLETED CAUSE OF DEATH	(ITEM 27) (Type,			<u>U)</u>	1010	00050	-//	20	75
	DR . SCHEMM - S	32. pegiştranıs signatu		ROC	KVI	LLE,	MD.	20850			
	NOV 28 1995	Jahr Diverse	Habak								



BALTIMORE, MARYLAND	THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the host	THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: It liem 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
B	ertificate be executed within 24 hours after	ng physician and completely filled in by ti giene prior to burial, cremation, or remov	other traumatic event, the medical
DIVISION OF VITAL RECORDS, P.O. BOX 68760	JAN: The law requires that the death c	rificate has been signed by the attendi	or Item 23 shows any injury, or
DIVISION OF	THE HOSPITAL OR ATTENDING PHYSIC	IN THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the 1 medium within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: It Item 28 is marked, (

	FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.									
	1. DECEDENT'S NAME (First, Middle, Last)	1.1			. DATE OF DEATH		3. TIME OF OEATH			
	JOSEPH	W	IDZG	SA N	OUEM BER	24 1895	12:15			
		SEX 6. AGE (In yrs. last birthday)		IF UNDER 24 HRS. 7.	DATE OF BIRTH	8. BIRT	HPLACE (State or Foreign			
	210 00 12//	(XM 2 ☐ F 90 YRS.			C1 10 10		YLAND			
DIRECTOR	9a. FACILITY NAME (If not institution, give street SHADY GROVE ADV			VILLE	н	MONTGO	MERY CO.			
EG	RESIDENCE OF DECEDENT									
DIR	MD. BALT	IMORE CITY	BALTI	MORE			LIMITS?			
FUNERAL	100. STREET AND NUMBER 1517- CLARKS		10g. CITIZEN OF WHAT COUNTRY? U • S • A •							
S		. WAS DECEDENT EVER IN U.S. ARMED			ORIGIN? (Specify Yea	or No- 14. RAC	E — American Indian,			
BY F	1 Never Married 2 Married 3 X Widowed 4 Divorced	FORCES? 1 TYES 2 NO IF YES, GIVE WAR OR DATES		olfy Cuban, Mexican, F	Puerto Rican, etc.)	Specify: WHITE				
ED 8	15. DECEDENT'S EDUCATION	ON 100 DECEMENTS		Task while or nin						
ETE	(Specify only highest grade com	pleted) (Give kind of	18a, DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working lile. Do NOT use relied.)			16b. KIND OF BUSINESS/INDUSTRY				
IPL.	12	STORE (OWNER							
E COMPLET	17. FATHER'S NAME (First, Middle, Last) JOHN WIDZGA	(First, Middle, Maiden S A WIZGEN	Sumame) VIA							
TO BE	19a. INFORMANT'S NAME (Type/Print) REV.DR. REICHARD	te Number, City or Town	r Town, State, Zip Code) VILLE, MD - 20850							
	20a. METHOD OF DISPOSITION	20b. PLACE AND DATE	OF DISPOSITION (Nam	ne of	DATE 20c. LOC	CATION — City or T	own, State			
	4 Donation 5 Other (Specify)	cemetery, cremetory or CEDAR H			1/28 BAI	LTIMORE	,MD.			
	21. SIGNATURE OF FUNERAL SERVICE LICENS	EE.		NG CO.,						
	W. W. 19708	my			ET, N.W.	, WASH.	, DC			
	23. PART I. Enter the diseases, or com- shock, or heart fallers. List	officialisms that caused the death. Do only one cause on each line.					Approximata Interval Between			
	IMMEDIATE CAUSE (Final	91 7 1	0	~1. 1	1		Onset and Death			
	disease or condition resulting in death)	laule My	cand	caling	ant,	M	11 days			
		QUE TO (OR AS A CONSEQUENCE OF	The Kin	+ 1	lung		a Carro			
NO NO	Sequentially list conditions,	DUE TO (OR AS A CONSEQUENCE O	Office of the second	ou p	- cu - c		11 chags			
SAT	if any, leading to immediate cause. Enter UNDERLYING	Hy Do Te	NSION.	110.			10 days			
Ē	CAUSE (Disease or injury that initiated aventa	DUE TO (OR AS A CONSEQUENCE O		1.0			01			
CERTIFICATION	resulting in death) LAST	Clark n	and ,	Laile	re		7 days			
AL C	PART II. Other aignificant conditions of	entributing to death but not resulting	in the underlying	causa given in Pa	rt i. 24a. WAS AN	AUTOPSY 24	b. WERE AUTOPSY FINDINGS			
CA	genemi		1	Ā	PERFOR		AVAILABLE PRIOR TO COMPLETION OF CAUSE			
MEDIC	Chronic /	Pastructive	Pulmar	on dise	and I	W NO	OF OEATH?			
AN: N	DID TOBACCO USE CONTRIB	THE TO CAUSE OF DEATH Y	ES INO I	UNCERTAIN						
CIAI	25. WAS CASE REFERRED TO MEDICAL EXAMINER?		ATH (Check only one)							
YSICI	1 TYES 2 NO	OSPITAL: Inpatient 2 ER/Outpatient 3 DOA	OTHER: 4 - Nursing Home	5 Residence 8	Other (Specify)					
РНҮ	27. MANNER OF DEATH 1 Netural 5 Pending	28a. DATE OF INJURY (Month, Day, Year) 28b. TII	JURY WOR	HCS	8d. DESCRIBE HOW IN	NJURY OCCURED				
8√	2 Accident Investigation	28 DI ACE OF INHIPM	M t YE							
ED	3 Suicide 8 Could not be 4 Homicide determined	28e. PLACE OF INJURY — At home, farm, building, etc. (Specify)	streat, factory, office	21	81. LOCATION (Street a City or Town, State)	ind Number or Rural	Route Number,			
LET	29a, CERTIFIER									
OMPLET		N: To the beat of my knowledge, death occur on the basis of examination and/or investigat					(e) and manner as stated			
O	29b. SIGNATURE AND TITLE OF CERTIFIER	1								
BE	Charless	1. Karosh	M. D	29c. LICENSE NUMBE	26	A A A A A	1 (Marth. Day, Year)			
10	30. NAME AND ADDRESS OF PERSON WHO CO	OMPLETED CAUSE OF DEATH (ITEM 27) (TYP)	Print)	1 Daire	Rock 1	1/- 1/10/	12886			
	31. DATE FILED (Month, Day, Year)	32 AGGISTRAB'S SIGNATURE	, 45,1111	10110	10ce VII	18 MIN	20000			
	NOV 28 1995	Jahn Mudear Reveals								

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FOR STATE REGIST
1. DECEDENT
MILDR
4. SOCIAL SE
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Ba. FACILITY I
Golde RESIDENC
10a, STATE
L. Carrier Victoria
10e. STREET
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11. MARITAL S
1 Never Mi
3 Widowed

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

_	REGISTRAR		C	EHIIF	ICALE	UF	DEATH		REG. NO.			
	1. DECEDENT'S NAME (First, Middle, Last) MILDRED ANN V	JOOD						2. DATE OF MONTH NOVEL	D/	16 ,	1995	3. TIME OF DEATH 12:20 A. M
	4. SOCIAL SECURITY NUMBER	5. SEX 1 M 2 F	6. AGE (In yrs. Is 81	YRS.	IF UNDER	1 YEAR DAYS	IF UNDER 24 HRS. HOURS MIN.		Day, Year)	101/	Country	•
	579-26-8480 BB. FACILITY NAME (If not institution, give si	21	01		OP CITY	TOWN C	OR LOCATION OF O		29,	1914 Virginia		
Œ	Golden Oaks Nursing Home					9b. CITY, TOWN OR LOCATION OF GEATH Laure1				Prince George's		
6	RESIDENCE OF DECEDENT	ing nome	-		La	ure	<u> </u>			Trince George's		
DIRECTOR	10a. STATE 10b. COUNTY				Washington, D.C.							10d, INSIDE CITY LIMITS? 1 X YES 2 NO
M	10e. STREET AND NUMBER		101. ZIP CODE							HAT COUNTRY?		
Ä	1125 12th Street				20005			Uni	ted S	tates		
BY FUNERAL	11. MARITAL STATUS 1 Never Married 2 Married 3 X Widowed 4 Divorced 12. WAS DECEDENT EVER IN U.S. FORCES? 1 X YES 2 IF YES, GIVE WAR OR OATES			ARMED 13. WAS DECENDENT OF HISPANI If yes, specify Cuban, Maxican 1 YES 2 X NO Specify:			in, Puarto Ric	n, Puarto Rican, etc.) Blaci			- American Indian, White, etc.): White	
0	15. DECEDENT'S EDU	16a. D	a. DECEDENT'S USUAL OCCUPATION			166. KIND OF BUSINESS/INDUSTRY						
E	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5 +)			(Give kind of work done during most of working life. Do NOT use retired.)								
AP.	6			Clerk		Departm			ment Store			
COMPLETED	17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NA			ME (First, Mic	ddie, Maiden	Sumame)		
BE (Unknown				Unknown							
10 8	19a. INFORMANT'S NAME (Type/Print)		1	96. MAILING	AILING ADDRESS (Street and Number or Rural Route Number, City or 1					own. State, Zip Code)		
Ĕ	Barbara A. Huff			911 (Cand1	.ewi	ck Stree	t, Ar	lingt	on,	Texas	76014
	20a, METHOD OF DISPOSITION 1 X Burial 2 Cremation 3 Ram 4 Donation 5 Other (Specify)	e AND DATE	TEOF DISPOSITION (Name of portion place) DATE 20c. LOCATION — City or coln Cemetery 11/20/95 Brentwood,									
	21. SIGNATURE OF FUNERAL SEMPICE LICENTIES					Fort Lincoln Funeral Home, Inc.						
		3401 Bladensburg Rd., Brentwood, MD 20722										MD 20722
	ahock, or heert fellure. List only one ceuse on each line. IMMEDIATE CAUSE (Final									Approximate interval Between Onset and Death		
NO	DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF):											
AT	If any, leading to immediate cause. Enter UNDERLYING	if any, leading to immediate										
CERTIFICATION	CAUSE (Disease or injury that initiated eventa resulting in death) LAST											
	DART II OAL - I - MI - A - A - A - A - A - A - A - A - A -		advista has a se		1- Ab	4 - 4 - 1 -						WERE AUTOPSY FINDINGS
IEDICAL	PART II. Other eignificant conditions contributing to death but not resulting ORGANIC BRAIN SYNDROME					P			PERFO	ERFORMED? MAILABLE PRIC COMPLETION OF DEATH?		AVAILABLE PRIOR TO COMPLETION OF CAUSE
. M	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN											
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO	HOSPITAL:	28. PL.	ACE OF DEA	OTHER	only one)			(Danall)			
478	27, MANNER OF DEATH	28a, DATE O		26b. Till	-	4 X Nursing Home 5 ☐ Racidence 6 ☐ Other (Specification of Control of Contro				<u></u>		
	1 X Natural 5 Pending		Day, Year)	IN	JURY		ORK?	2ad. DESCRIBE HOW INJURY OCCURED				
ED BY	2 Accident Investigation 3 Suicide 6 Could not be determined 28e. PLACE OF INJURY — At home, fact building, atc. (Specify)								281. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
COMPLET	29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the bast of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.									hates as renoem hos (
8												,
BE	296. SIGNATURE AND TITLE OF CERTIFIER				29c. LICENSE MU			MBER 294. DATE		1/ //	(Month) Day, Year)	
10	100	ayl.) 100 OF 221111	184	D25430				11/17/97			
	JOHN MARGOLIS, M.D., 14333 LAUREL-BOWIE ROAD, #307, LAUREL, MARYLAND 20708									20708		
	NOV 2 9 1995	32 AEGISTA	AR'S SIGNATURE	and the								

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BALTIMORE, MARYLAND 2121	retained by the hospital or atten
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DIVISION OF VITAL RECORDS, P.O. BOX 687

houl		9e. FACILITY NAME (If not institution, giv	e street end number)		9b. CI1
2, 3 should	DIRECTOR	Herman Wilson He	ealth Care Cer	nter	
physician. burial-transit permit. Pages 1,	8	10e. STATE 10b. COUL	NTY	10c. CITY	r, TOWN
26	뜸	Marriland Drin	no Coorrola		t.
mit.		Maryland Prince	ce George's		Le
- B	A A				
an.	빌	8306 Arden Lane			
rial-t	FUNERAL	11. MARITAL STATUS	12. WAS OECEDENT EVER I	N U.S. ARMED 2 ⊠ NO	13
the by	ВУ	1 Never Merried 2 Merried 3 Wildowed 4 Divorced	IF YES, GIVE WAR OR D		
as th					
death. Page 6 may be retained by the hospital or attending physician is threeful director, page 5 should be detached for use as the burial-train examiner must be notified at once.	COMPLETED	15. DECEDENT'S E (Specify only highest gra		16a. DECEDENT'S (Give kind of v	vork don
10 JO	Ш	Elementery/Secondary (0-12)	College (1-4 or 5+)	life. Do NOT us	e retired.
Spide Spide	A D		4	Retir	ed '
the hospit detached once.	Ö	17. FATHER'S NAME (First, Middle, Last)			
# & &	BE (Francis X. Pall	emon		
should to	8	19e. INFORMANT'S NAME (Type/Print)		19b. MAILING	ADDRE
reta 5 sh	2	Sylvia Williams	Averv	8306	
ay be		20e. METHOD OF DISPOSITION			
Tor tor		1 X Buriel 2 - Cremetion 3 - Re	emoval from State	netery, crematory or of	her place
death. Page 6 may be retained by the house e funeral director, page 5 should be detach!		4 ☐ Donation 5 ☐ Other (Specify)		<u>rbutus Me</u>	emor
nin P		21. SIGNATURE OF FUNERAL SERVICE	LICENSEE 1		22
deat deat		Lohn.	Stournat	7//	1
hours after death. Page 6 may d in by the funeral director, pa or removal.		23. PART i. Enter the diseases, o	or complications that cause	d the death. Do n	ot ente
ours after d in by th or remova		shock, or heart fallur	e. List only one cause on e		
filled tion.		IMMEDIATE CAUSE (Final disease or condition		1	1
ately mt. 1		resulting in death)	a. Males	Mul 1	Dec
ertificate be executed withing physician and complete giene prior to burlat, creminather traumatic event,			DIVE TO (OR AS)	A CONSEQUENCE OF): A(
ate be executed whysician and compression to burlal, critical articles in traumattic every	Z	Samuandalla llata an dolara	. allea	Tilor	ill
an ar	일	Sequentielly list conditions, if any, leading to immediate	OUE TO JOR AS	A CONSEQUENCE OF): <u>/</u>
prior	8	cause. Enter UNDERLYING CAUSE (Disease or Injury	a lund	1/8/11	1 1
tifica g ph	臣	that initiated events	OUE TO (OR AS	A CONSEQUENCE OF):
endin Hyg	CERTIFICATION	resulting in death) LAST	d.		
he death certificate be executed with mours after death. Page 6 m the attending physician and completely filled in by the funeral director, Mental Hygnene prior to burial, cremation, or removal.					
SIGIAN: The law requires that the death certificate be executed with Scarlificate has been signed by the attending physician and comple in the State Dept. of Health and Mental Hygnere prior to burial, cret d, or item 23 shows any Injury, or other traumatic even	MEDICAL	PART II. Other aignificent conditi	ona contributing to deeth I	put not resulting I	n the t
that thar ar	일	Abelle list	are series	ulia!	
requires een sign of Heal	Ä	abletint	1 Kelluly	Desi	200
AN: The law requires that the death certific fircate has been signed by the attending by is State Dent. of Health and Mental Hygiena litem 23 shows any Injury, or othe	~	DID TOBACCO USE	CONTRIBUTE TO	CAUSE OF	DEA
has been Dept 23	HYSICIAN:	25. WAS CASE REFERRED TO MEDICAL	CONTINUOUS IG	CAUSE OF	DU
Cate h	힐	EXAMINERY 1 YES 2 SANO	HOSPITAL:		QТM
SICIAN: The certificate h the State h	₹	27. MANNER OF DEATH	1 Inpatient 2 ER/Out		136/
	표	1 Natural 5 Pending	28s. DATE OF INJURY (Month, Day, West)	28b. TIMI	URY
ING PHI Ifter this eath wi	BY	Accident investigation			М
NDIN A		3 - Suickle 6 - Could not b		f — At home, farm, a	treet, fo
OR ATTENDING DIRECTOR After hours after death		4 Momicide determined	(I I I I I I I I I I I I I I I I I I I		
OR / DIRE hours	۳۱	290. CERTIFIER 1 CERTIFYING PH	YSICIAN: To the best of my know	dedee death com-	
TAL 72	COMPLETED	onel only 21	INER: On the basis of examination		
HOSPITAL FUNERAL WITHIN 72 I	8			Char investigatio	n, ni my
THE HOSPITAL OR ATTENDING PH THE FUNERAL DIRECTOR: After thin filed within 72 hours after death w PORTANT: If Item 28 is marke	BE (200. SIGNATURE AND TITLE OF CERTIF	TIER ALAL- ALD		
PPSE	0	then ? Yel	Lewny		
	F	30. NAME AND ADDRESS OF PERSON	WHO COMPLETED CAUSE OF DE		
(2)	1 1	TIKOA BIDI	=1110 19	711/12	777

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

	FOR STATE REGISTRAR	STATE OF MARYL		ENT OF HEAD		NTAL HYGIEN	E				
	1. DECEDENT'S NAME (First, Middle, Last)							2. DATE OF DEATH 3. TIME OF DEATH			
,	Agnes Pallem	gnes Pallemon Williams						95 1:45 A. M			
- 1	4. SOCIAL SECURITY NUMBER		n yrs. last birthday) F		NOER 24 HRS. 7.	DATE OF BIRTH	0.1	BIRTHPLACE (State or Foreign			
Ì	111-38-5998 9e. FACILITY NAME (If not inetitution, give s		B1 YAS.	CITY, TOWN OR LO	J	(Month, Day, Year)		en Antonio, TX			
DIRECTOR	Herman Wilson Hea		Gaither				tgomery				
မ္ဘ	10e, STATE 10b, COUNTY	1	10c. CITY, TO	OWN OR LOCATION				10d. INSIDE CITY LIMITS?			
	Maryland Prince George's F			. Washington			1 ∑ YES 2 ☐ NO				
FUNERAL	8306 Arden Lane	20744			-37	ed States					
5	11. MARITAL STATUS	12. WAS DECEDENT EVER IN FORCES? 1 YES					or No 14.	14. RACE — American Indien,			
BY	1 Never Merried 2 Merried 3 Wildowed 4 Divorced	Z K NO					Bleck, White, etc. Specify:				
						Black					
	15. DECEDENT'S EDUC (Specify only highest grade	completed)	(Give kind of work	DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)			INESS/INDUST	TRY			
COMPLET	Elementery/Secondary (U-12) College (1-4 or 5 +)			Teacher		Gover	nment				
S						(First, Middle, Meiden	Surname)				
	Francis X. Palle	mon		sey Lee Appling							
O BE	19e. INFORMANT'S NAME (Type/Print)					DDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)					
ř	Sylvia Williams A	very	Ft. Wa	Washington, MD 20744							
	20e. METHOD OF DISPOSITION 1 X Burtel 2 Cremetion 3 Removal from State 4 Donatton 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of camelery, crematory or other piace) Arbutus Memorial Garden 11/30/95 Arbutus, Maryland										
	21. SIGNATURE OF FUNERAL SERVICE LIC		butus Melli	22. NAME AND AD	ORESS OF FACILIT	TY	ALDULU	s, Maryranu			
	* John T	Stowast	777		FUNERAL		7.7 = -1- 1				
ᅥ	23. PART i. Enter the diseases, or o	complications that caused	the desth. Do not	enter the mode o	f dving, such a	odu, N.L.	, wasni	ngton, D. C.			
	shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition										
	a. Old TO (oh AS)A CONSEQUENCE OF):										
CERTIFICATION	Sequentielly list conditions, if any, leading to immediate b. Out TO (OR AS A CONSEQUENCE OF):										
5	CAUSE (Disease or Injury	· Wind	Value	molas	LA						
=	that initiated events resulting in death) LAST	OUE TO (OR AS 'A	CONSEQUENCE OF):	0							
Ħ H	d										
١	PERFORMED? AMAILABLE PRIOR TO							24b. WERE AUTOPSY FINOINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE			
	CALLE OF A NO OF DE							OF DEATH?			
Σ ∥	DID TORACCO USE	CONTRIBUTE TO	CAUSE OF D	EATH VEC	- NO 3			1 TYES 2 NO			
<u> </u>	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO 25. PLACE OF DEATH (Cross only loss) 26. PLACE OF DEATH (Cross) only loss)										
HYSICIAN:	25. WAS CASE REFERRED TO MEDICAL				or passant language	and dead					
≻ II	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:		WER:	Busidence 8 (Other (Specific)					
₹ II	EXAMINERT C	1 Inpatient 2 I ET/Outp	255. TIME OF	Numing Home 5		Other (Specify) d. DESCRIBE HOW II	UURY OCCUR	ED			
٦.	EXAMINERY 1 YES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending	1 I Inpetient 2 I ER/Outp	stient 3 DOA 4	Work?			CURY OCCUR	ED			
2 2	EXAMINERY 1 YES 2 HO 27. MANNER OF DEATH 1 Natural 5 Pending Investigation 3 Suicide 6 Could not be	1 Dipotion 2 ET/Outp 28s. DATE OF INJURY (Month, Deg. Weer) 28s. PLACE OF INJURY	28b. TIME OF BLAURY	M 1 YES	2 HO	d. DESCRIBE HOW II					
2 2	EXAMINERY 1 YES 2 NO 27. MAINSEN OF DEATH 1 Natural 5 Pending Investigation	1 Inpatient 2 Input Property (Month, Dep. Weer)	28b. TIME OF BLAURY	M 1 YES	2 HO	d. DESCRIBE HOW II					
2 2	EXAMINERY 1 YES 2 NO 27. Manisher OF DEATH 1 Ancident Solution Neuron 1 Accident Novestigation 3 Suicible Could not be determined 29e. CERTIFIER (Check only	1 Inpetient 2 EN/Outp 28s. DATE OF INJURY (Month, Dec Wee) 28s. PLACE OF INJURY building, etc. (Speci	28b. TIME OF BLAZEY At home, fam., stree	THEFT: Amening Home 5 28E. INJURY WORK? M T YES 1, factory, office	2 NO 28	d. DESCRIBE HOW II E. LOCATION (Street a City or Town, State) the cause(e) and man	nd Number ar i	Rural Route Number,			
COMPLETED BY P	EXAMINERT YEB 2 NO II. MAINTER OF DEATH Netural Pending Investigation	28s. DATE OF INJURY (Month, Des Weer) 28s. PLACE OF INJURY (Minch, Des Weer) 28s. PLACE OF INJURY (Minch Des Weer)	28b. TIME OF BLAZEY At home, fam., stree	THEFT: Thursing Home 5 28c. INJURY WORK? T VES T, factory, office the time, date and in my opinion, death	2 NO 28	d. DESCRIBE HOW II E. LOCATION (filtrer a City or Town, State) the cause(e) and men e, date and place, en	nd Number or i	turel Route Number.			
BE COMPLETED BY P	EXAMINERY 1 YES 2 NO 27. Manisher OF DEATH 1 Ancident Solution Neuron 1 Accident Novestigation 3 Suicible Could not be determined 29e. CERTIFIER (Check only	28s. DATE OF INJURY (Month, Des Weer) 28s. PLACE OF INJURY (Minch, Des Weer) 28s. PLACE OF INJURY (Minch Des Weer)	28b. TIME OF BLAZEY At home, fam., stree	THEFT: Thursing Home 5 28c. INJURY WORK? T VES T, factory, office the time, date and in my opinion, death	2 NO 28	d. DESCRIBE HOW II E. LOCATION (filtrer a City or Town, State) the cause(e) and men e, date and place, en	nd Number or i	Rural Route Number			
2 2	EXAMINERT YEB 2 NO II. MAINTER OF DEATH Netural Pending Investigation	2 Inputient 2 ET/Output 28s. DATE OF INJURY (Moork, Day Wee) 28s. PLACE OF INJURY building, etc. (Speci	At home, farm, stree adge, death occurred at end/or Investigation, in	THEFT: Throing Home 5 28E. MUUHY WORK? I VES 1, factory, office I the time, date end I my opinion, death	2 NO 28	d. DESCRIBE HOW II E. LOCATION (filtrer a City or Town, State) the cause(e) and men e, date and place, en	nd Number or i	turel Route Number.			

FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Lest)

		1. DECEDENT'S NAME (First,	, Middle, Last)								2. OATE OF O	DEATH		YEAR	3. TIME OF DE	ATH
	1	WILLIAM		V	VARDI	ELL		WI	LLIAN	1S	DEC.		199		8:05	Ам
		4. SOCIAL SECURITY NUME		5. SEX	6. AGE (In	yrs. last birti	440MT	INDER 1 YEAR	IF UNDER	24 HRS.	7. DATE OF E (Month, De	w Weerl		Country	LACE (Statu or	
Pg.		150-32-0868		1 M 2 D F	53	٧	rRS.				JAN.	22,			JERSEY	
2, 3 should	OR	9a. FACILITY NAME (If not in 3737 PECA	N COU				1	VALD	OR LOCATION	ON OF DE	ATH			ARLI		
w.	DIRECTOR	RESIDENCE OF DEC	10b. COUNT	Υ		10	10c. CITY, TOWN OR LOCATION								10d, INSIDE CI	TY
r. Pag	DIR	MARYLAND	CHA	RLES		,	WALDO	RF						LIMITS?		
permi	AL	10e. STREET AND NUMBER				101. ZIP CODE							10g. CITIZ	EN OF W	HAT COUNTRY	?
ansit	FUNER	#3737 PECAN	OUR!						20602					ED S	TATES	
urial-ti		11. MARITAL STATUS 1 Never Married 2	Married	12. WAS DECEDEN	X YES	2 NO		If yes,	specify Cubs	ENT OF HISPANIC ORIGIN? (Specify Yea or No Cuban, Maxican, Puarto Rican, atc.)				Black,	14. RACE — American Indian, Black, White, etc.	
as the burial-transit permit, Pages	ВҰ		Widowed 4 Divorced IF YES, GIVE WA					1 🗌 YE	s 2XXNO	Specify	Specify:				BLACK	
use as	ED		15. OECEDENT'S EDUCATION (Specify only highest grade completed)				ENT'S USU/	done during i	FION nost of workli	ng			SINESS/IND			
1 for	LETI	Elementary/Secondary (0		College (1-4 or 5	+)		NOT use retii CE OF		2				MENT	_	THE LUMBIA	
be detached for at once.	COMPL	17. FATHER'S NAME (First, M								HER'S NA	ME (First, Midd			r CO	LUMBIA	
at o	BE C	UNKNOWN									ETTE V					
5 should notified	TO B	19a. INFORMANT'S NAME (Type/Print)		-						Route Number, (
page 5	F	ELLEN JEANE								AD, A	ALEXAN	_				11
funeral director, page 5 should xaminer must be notified		20a METHOD OF DISPOSIT		ovel from Stats		PLACE AND LETY, Cremeto LTE R				12/	DATE		CATION — (CEV
d direc		4 ☐ Donation 6 ☐ Other 21. SIGNATURE OF FUNERA	L SERVICE LI		_ Wn.			-			L1/95			IN, IN.	EW JER	SEI
funeral dir examiner		aydia		unton	TONI		200				RAL HO			יידו זא		2064
d in by the or removal.			ZYDIA C. THORNTON JOHNSON M00583 #3439 LIVINGSTON ROAD, INDIAN HEAD, MD.2064													
pletely fille cremation, vent, the		23. PART I. Enfor the diseases, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory errest, Approximate Interval Between ender feliure. Liet only one ceuse on each line. IMMEDIATE CAUSE (Finel disease or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF):														
and co buria	CATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury														
- 6	CERTIFICATION	that initiated events resulting in death) LAST d														
n signed by the afti f Health and Menta ows any injury,	MEDICAL	PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 24a. WAS AN AUTOPSY PRIOR TO COMPLETION OF CAU DF DEATH? 1 Dres 2 No											OR TO OF CAUSE			
of H		DID TOBACCO U	ISE CONT	RIBLITE TO CA	ALISE OI	F DEATH	YES I		INC	FRTAI		part	ar		1 NES 2	NO
has the Dept	PHYSICIAN:	25. WAS CASE REFERRED 1				8. PLACE O				LKIAI	101			1		
tificate e Stati	SIC	1 XYES 2 NO		HOSPITAL:	☐ ER/Outpu	rtlant 3 🗆 i	DOA 4	HER: Nursing H	ome 5 🗆 R	asidenca	XXOther (S)		ON S	TREE	ET IN	CAR
this cer h with th arked, c			Pending Investigation	280. DATE OF	Day, Year)	11	BB. TIME OF DUHURA POO A	- 1	NJURY AT WORK? YES 2	y'NO	SENE-	BE HOW I	ictee	URED U	nshot	
R. Afte	D BY		Could not be	26s. PLACE		— At home,	farm, street	t, factory, of	fica		281. LOCATIO	ON (Street lown, State)	and Number	or Rural A	oute Number,	4
RECTOR:	ETE	4 Homicide	datarmined	1		-	Stree	2 -			Wale	torf	Me		N C FAF	/
TO THE FOST FIRE OF AT ENGINE FIT SOURCE. THE AT OF THE FORT IN THE SERVICE HAS BEEN BEEN BEEN BEEN BEEN BEEN BEEN BEE	COMPLETED	(and an army		ER: On the best of											and manner a	s stated.
HE FUI	BE C	296. SIONATURE AND TITLE	E OF CERTIFIE	R	n	120			29c. LIC	ENSE NUI	WBER		29d. DATE	E SIGNED	(Month, Day, Ye	ar)
D B M	TO B	/ Lc	em	in fl.	Chr	ite 1	(A)		0.	C.M	.E.	DE	CLMB	ER 4	, 199	95
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		31. DATE FILED (Month, Day,		32. REGISTR	AR'S SIGNA	TURE		Stre	eet,	RgT	timor	e,	mary	1an(1 2120	7.T
		DEC	6 199	5 Julia	Davel	sor Ran	dall									
,															DHMI	1-16 Rev 1/8

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

3. TIME OF DEATH

2. DATE OF DEATH MONTH

STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

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DIVISION OF	

Frances Marguerite Warner 1995 2005 hrs November 9 4. SOCIAL SECURITY NUMBER 5. SEX 8. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year B. BIRTHPLACE (State or Foreign Country) 1 M 2 XX DAYS HOURS 193-38-0718 81 YRS. June 27, 1914 **Pennsylvania** permit. Pages 1, 2, 3 should 9e. FACILITY NAME (If not institution, give street and number) 9b. CITY. TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR 10731 Kasota Road Chesapeake Landing (At Hone) Chestertown Kent RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Kent Chestertown 1 YES 2 NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10o, CITIZEN OF WHAT COUNTRY? 10731. Kasota Road - Chesapeake Landing the funeral director, page 5 should be detached for use as the burial-transit 21620 United States Page 6 may be retained by the hospital or attending physician. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-It yes, specify Cuben, Mexicen, Puerto Rican, atc.) 14. RACE — American Indian, Black, White, atc. FORCES? 1 YES 2 IF YES, GIVE WAR OR DATES 1 Never Merried 2 Merried 1 TYES 2 X NO 3 Widowed 4 Divorced BY Specify: White 15. DECEDENT'S EDUCATION 18e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade COMPLET Elementary/Secondary (0-12) College (1-4 or 5 +) Homemaker Domestic - Own Home 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname, notified at Francis LeBaron DeSilver Gladys Marguerite Hunter **BE** 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 C. Anne Reid 475 Greentree Road, Sewell New Jersev ě 20e. METHOD OF DISPOSITION
1 □ Buriel 2 □ Cremetion 3 □ Removal from State
4 □ Donetion 5 □ Other (Specify) 20c. LOCATION — City or Town, State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE must cemetery crematory or other piece; old Crematory - November 13, 1995 Dover, Delaware examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Fellows - Wells Funeral Home 21620 King Jr William | 413 West High Street, Chestertown Maryland medical 23. PART I. Enter the diseases, or complications that saused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, filled in by Approximata shock, or heart failure. List only one cause on each line. 24 hours Intarval Between IMMEDIATE CAUSE (Final Onset and Death CITOBLASTOMA MUITIFORME the disease or condition 12 completely 9 event, reaulting in death) DUE TO (OR AS A CONSEQUENCE OF): burial, traumatic CERTIFICATION and Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): 2 If any, leading to immediate cause. Enter UNDERLYING attending physician prior CAUSE (Disease or Injury other 1 DUE TO (OR AS A CONSEQUENCE OF): that initiated events reaulting in death) LAST 0 the atten Mental A Injury, PART II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO MEDICAL and a HO any Signed I COMPLETION OF CAUSE 1 YES 2 NO OF DEATH? shows 1 TES 2 NO certificate has been in the State Dept. of DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH

WAS CASE REFERRED O MEDICAL AS PLAGE OF PHYSICIAN: YES NO UNCERTAIN 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one)

OTHER:

OTHER: Item **EXAMINER?** OSPITAL: 1 | YES 2 | 10 me 5 Residence 8 Other (Specify) 0 280. DATE OF INJURY (Month, Del. Year) 27. MANNEY OF DEATH 28b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED with is marked, this 1 Netural м 1 YES 2 NO BY After 2 Accident Investigation 28e. PLACE OF INJURY — At home, term, street, tectory, office 28t. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Sulcide COMPLETED 6 Could not be DIRECTOR: after 28 is 4 Homicide hours item DR 29e. CERTIFIER CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the ceuse(s) end menner es stated. FUNERAL I within 72 h (Check only one) TO THE HOSPITA
TO THE FUNERA
De filed within 7.
IMPORTANT: I MEDICAL EXAMINER: On the begin of examination end/or investigation, in my opinion, death occured at the time, date end piece, end due to the ceuse(s) end menner as stated. 296. SHONATURE AND TITLE OF CENTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Manth, Day, Year) 8 6 10 2 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) TRICK 31. DATE FILED (Mo 32. REGISTRAR'S SIGNATURE '95 Julia Davidson-Randall

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

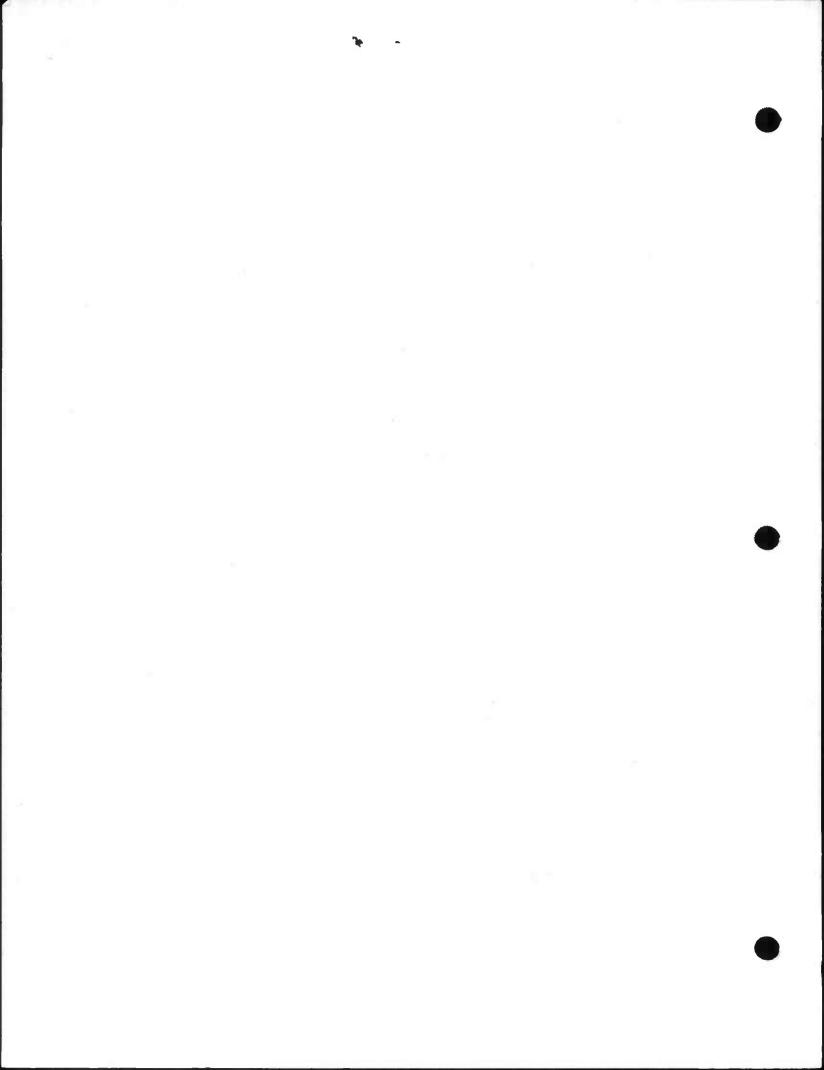
BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatte event, the medical examiner must be notified at once. TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

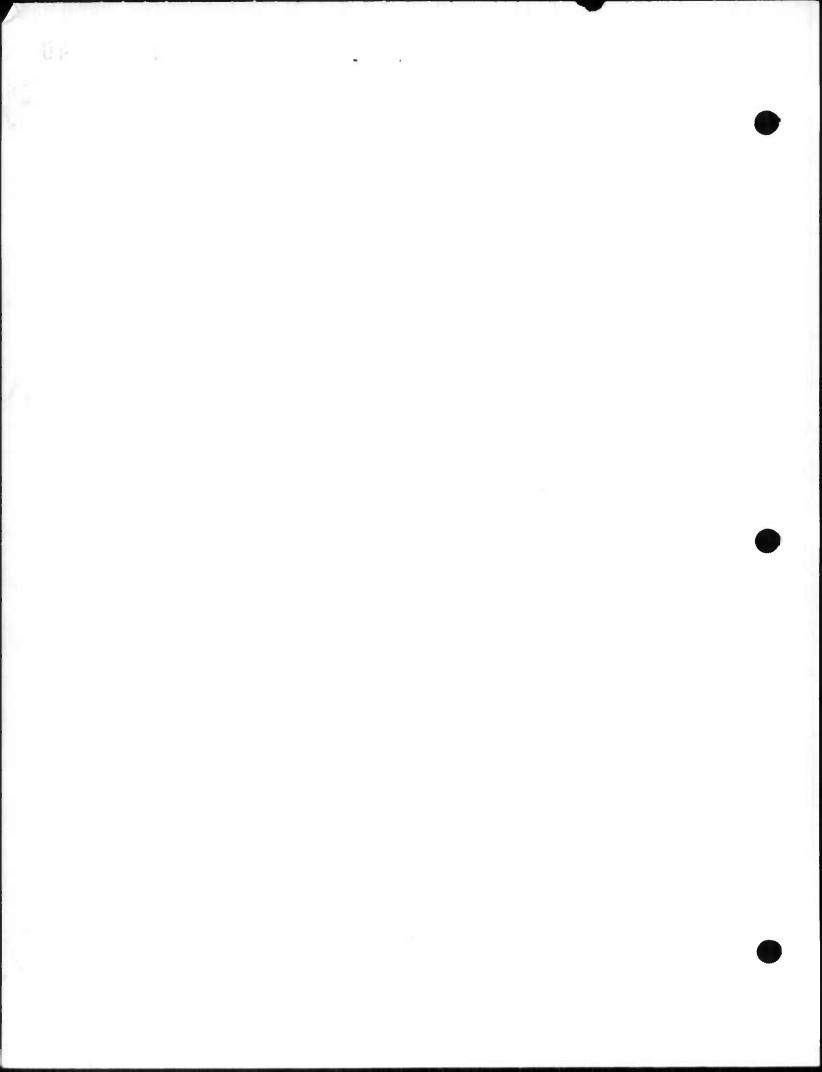
	1 - FOR STATE REGISTRAR	STATE OF MARYLA	ND / DEPARTN Certific			MENTAL HYGIEN REG. NO												
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH		3. TIME OF DEATN										
1	Pearly May Crigg	er Whitlow				November 1	16 1005	1056 hrs M										
- 0			yrs. lest birthday) IF	UNDER t YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH		RTNPLACE (State or Foreign										
	2000 00 1000	1 □ M 2 XX 69	YRS.		HOURS MIN.		, 1926 We	est Virginia										
Or.	9a. FACILITY NAME (If not institution, give stre	(AJ	HOME)		R LOCATION OF DI	EATH	9c. COUNTY O											
DIRECTOR	7051 Augustine Her	man Highway		Ceo	cilton		Cec	cil										
3EC	10a. STATE 10b. COUNTY		10c. CITY, TO	OWN OR LOCATIO	ON			10d. INSIDE CITY										
	Maryland Cec	il		Ced	cilton			1 TYES 2 NO										
AL	10e. STREET AND NUMBER			101.	ZIP CODE		10g. CITIZEN OF WHAT COUNTRY?											
FUNERAL	7051 Augustine Her				21913		United	l States										
5	11. MARITAL STATUS 1 Never Merried 2 Married	12. WAS DECEDENT EVER IN FORCES? 1 YES	U.S. ARMED			NIC ORIGIN? (Specify Year, Puerto Rican, etc.)	s or No — 14, R	ACE - American Indian, lack, White, etc.										
В	3 Widowed 4 X Divorced	IF YES, GIVE WAR OR DAT			2 NO Specif		S	pecify:										
	15. DECEDENT'S EDUCA	TION	18a. DECEDENT'S USI	JAL OCCUPATION	N	185 KIND OF BU	SINESS/INDUSTR	White										
E	(Specify only highest grade co	ompleted) College (1-4 or 5+)	(Give kind of work life. Do NOT use re	done during most	t of working	Too. Killo of Bo	311/E33/11/03/1A	·										
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementery/Secondary (0-12) 2 16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker 16. KIND OF BUSINESS/INDUSTRY Domestic / Own Home 17. FATNER'S NAME (First, Middle, Last) 18. MOTNER'S NAME (First, Middle, Maiden Surname)																		
S S	17. FATNER'S NAME (First, Middle, Last)				18. MOTNER'S NA	ME (First, Middle, Maiden	Surname)											
BE C	Jess Crigger				Gra	ace Godsey												
Terry Ann Shannon 190. MAILING ADDRESS (Street and Number or Rural Route Number, City or Yown, State, Zip Code) Maryland 21																		
													4 Donation 5 Other (Specify)	ltan, Mar	aryland			
													Zion Cemetery - November 21, 1995 Cecilton, Maryland 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Fellows Funeral Homes, P.A.					
			17.	226 Eas	st Main	Street, Co	ecilton.	Maryland 219										
	23. PART I. Enter the diseases, or col	William L. King Jr. 226 East Main Street, Cecilton, Maryland 210 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate																
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		and and	ipsol	0100	Sic			1.95										
	disease or condition resulting in death) e. arteriosclevesis Due to (or as a conscouence or):																	
	resulting in death) e.				212 .			3										
NO					312 .			Twos										
ATION	Sequentially list conditions, if any, leeding to immediate		CONSEQUENCE OF):			12-12-		1 mos										
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31. DATE FILED (Month, Day, Year)

NOV 9 '95

		1 - STATE REGISTRAR	STATE OF MARY			MENT				MENTAL HYGIEN REG. NO.				
		1. DECEDENT'S NAME (First, Middle, Last)								2. DATE OF DEATH			3. TIME OF DEATH	
		Virginia Plumme	er Walle							MONTH DA		YEAR		
				(In yrs. last bir	ethelas)	IF UNDER 1	WEAD !	IF UNDER	24.4500	NOV. 8, 19	95		7:30 A	
		219-07-6655-A				1		HOURS	MIN.	(Month, Day, Year)		Country)		
pin		9e. FACILITY NAME (If not institution, give street		92						Jan.21,1				
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<u> </u>	5	RESIDENCE OF DECEDENT												
Pages	DIRE	10a. STATE 10b. COUNTY		1	Oc. CITY,	TOWN OR	LOCATIO	NC				- 1	IOd. INSIDE CITY	
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	ERAL	100. STREET AND NUMBER Apt. 2-B Morgi	nec Villa	ge			101.	ZIP CODE	1620)	10g. CITI	U.S	A .	
Cian.	FUN	11, MARITAL STATUS 1	2. WAS DECEDENT EVER	IN U.S. ARMED 13. WAS DECENDENT OF HISPAN					E HISDAM				- American Indian,	
215-0020 attending physician. Ise as the bunal-transit	BY FI	1 Never Married 2 Merried	FORCES? 1 YES	2 2 00		Hy	yes, spec		, Mexican	n, Puerto Ricen, atc.) Bie			White, etc.	
215-00 attending p	0	15. DECEDENT'S EDUCAT		16a. OECEDENT'S USUAL OCCUPATION						16b. KIND OF BUS	INESS/IND	LISTRY		
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D 2 2 D	립	11	College (1-4 or 5+)											
the host	COMPL	17. FATHER'S NAME (First, Middle, Last)						16. MOTH	ER'S NAM	ME (First, Middle, Meiden	Sumemel			
# 8 % X	0	Frank A. Plummen	r							ane Hawk				
MAR retained 5 should notified	00	19e. INFORMANT'S NAME (Type/Print)		19b. M	IAILING A	DDRESS (Street en			oute Number, City or Town		Codel		
	임	Mrs. Della P. Ri	ichardson							stertown			1620	
ALTIMORE, death. Page 6 may be funeral director, page . xaminer must be		20e. METHOD OF DISPOSITION	20	b. PLACE AND	DATEOF	DISPOSITI	ION (Nam	e of		DATE 20c. LO	CATION —	City or Town	n, State	
Page 6 may i director, pa		Buriel 2 Cremation 3 Remove	of trom Stala	metery, cremate	ory or other	er place)	7 C	amat	NC	v.11,199	5	-277	EM -	
Pag al di		21. SIGNATURE OF PUNERAL SERVICE LICEN)))			22. N/	AME AND	ADDRES	S OF FAC	ILITY			•	
death. Pag funeral di J. examiner		> 1/2 /5	16/1	1.		Tor	m He	eļf∈	enbe	in Funer	al I	Home	s, P.A.	
		555 Main St., Church Hill, Md. 2162												
		shock, or heart failure. Lis	it only one cause on a	ach iine.	i. Do no	t enter tr	he mod	a of dylr	ng, such	ss cardisc or respi	ratory arr	est,	Approximata Interval Between	
y filled tion, or the m		DAMEDIATE CALICE (First												
# 3 E -		disease or condition reaulting in death) a. Ceneralized arteriorsclerosis Due to (or as agonseouence of):												
ecuted within nd complete burial, crema			DUE TO (OR AS	AGONSEOUE	NCE OF):	:								
executed with and complete the burial, cres	ERTIFICATION	Sequentially list conditions, b.	OUE TO (OR AS	A CONSEQUE	NCE OE							_		
tage of the control o	AT	If sny, laading to immediata csuse. Enter UNDERLYING	(0			'								
certificate ding physical principle	윤	CAUSE (Disease or Injury C												
Fygie	E	that initiated events reaulting in death) LAST												
	S	d											+	
0 2 3 -	CAL	PART II. Other significant conditions								Part I. 24s. WAS AN			VERE AUTOPSY FINDINGS	
3 5 8 E		asthma G	DAKA C	mynn	tal	ion	(2)	Reg	2	PERFOR		C	MAILABLE PRIOR TO COMPLETION OF CAUSE	
v requires the been signed it. of Health is shows an	MEDI	3 tx 4 Frank	Cellarte	ati (400	atri	al	2%	ella	_			F OEATH?	
w requi been s or, of H	=	DID TOBACCO USE CONTRIE	BUTE TO CAUSE O	OF DEATH	YES	DN	OI	UNC	ERTAIN					
TAL MEC The faw requires the has been sign ate Dept. of Healt em 23 shows	SICIAN:	25. WAS CASE REFERRED TO MEDICAL		26. PLACE O		(Check onl	ly one)							
MN: The ficate State	Sic		IOSPITAL: Inputient 2 ER/Out	patient 3 🗆 I	DOA 4	OTHER:	n Home	5 Res	idence d	Other (Specify)				
Sicia certif	РНУ	27. MANNER OF DEATN	28a. OATE OF INJURY		8b. TIME	OF 21	8c. INJU			28d. DESCRIBE NOW IN	JURY OCC	URED		
PHYS This h		1 Natural 5 Pending	(Month, Day, Year)		INJUR		WOR	K? S 2 □						
After death	BY	2 Accident Investigation 3 Suicide 8 Could not be	28a. PLACE OF INJUR	Y — Al home,	Jarm, str					281. LOCATION (Street e	nd Number	or Rural Rou	de Number	
DR ATTENDING PHYSICIAN: DIRECTOR: After this certifica hours after death with the Siz Item 28 is marked, or lit		4 Homicide determined	building, atc. (Spe	ocify)						City or Town, State)		0. 7.0.0	to running,	
S E D E	MPLET	290. CERTIFIER	N. To the best of the last	2										
TAL SAL	MP	(Check only one)												
OSP UNE	8	2 MEDICAL EXAMINER:	On the besie of examination	on end/or invel	atigation,	in my opir	nion, des	th occure	d at the t	ime, date end place, end	dua to the	e cause(e) e	nd menner ee stated.	
를 등 등	BE	29b. SIGNATURE AND TITLE OF CERTIFIER	10 -				1	29c. LICE					fonth, Day, Year)	
TO THE HOSPITAL OF THE FUNERAL DE FIER WITHIN 72 NO IMPORTANT: If IN	70	1 all our,	MD.					0	213	13	▶ N	ov.9	,1995	
	-	30. NAME AND ADDRESS OF PERSON WHO C												
		Kim Wun, M.D.,			eet,	, Ch	est	ert	own	, Marylaı	nd 2	1620		
		31. DATE FILED (Month, Day, Year)	32 REGISTRAR'S SIGN	VATURE										
	1	NOV 9 '95	Julia Davidson	r-lianda	12									



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FOR STATE REGISTRAR CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH YEAR Jesse Wilson 1995 Nov 4:00 p 4. SOCIAL SECURITY NUMBER 219-07-7224 5. SEX 6. AGE (in yrs. last birthday) IF UNDER 1 YEAR 7. DATE OF BIRTH IF UNDER 24 HRS. 6. BIRTHPLACE (State or Foreign (Month, Day, Year) 9-10-1921 74 MD Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF OFATH DIRECTOR Magnolia Hall Nursing Home Chestertown Kent RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Kent Worton 1 YES 2 NO permit. 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? burial-transit Lamb¹s Meadow Road 21678 U.S.A. Page 6 may be retained by the hospital or attending physician. 11. MARITAL STATUS 12. WAS DECEDENT EYER IN U.S. ARMED FORCES? 1 YES 2 HO IF YES, GIVE WAR OR DATES 13. WAS OECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Maxican, Puerto Rican, etc.)
1 YES 21 70 Specify: 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Married B Specify: use as the l 3 Widowed 4 Divorced **Black** ETED. 16e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b, KIND OF BUSINESS/INDUSTRY (Specify only highe page 5 should be detached for Elementary/Secondary (0-12) College (1-4 pr 5 +) COMPL 0 - 11Labor Construction 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Malden Surname) notified at Isaac Wilson Emma Butler m 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Mrs. Carrie Wilson P. O. Box # Worton, MD 21678 pe 20a. METHOD OF DISPOSITION

Buriat 2 Cremation 3 Removal from State 20c. LOCATION — City or Town, State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE must n by the funeral director, removal. Mt. Olive Cemetery □ Donation 5 □ Other (Specify) Worton, MD examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY
Walley Funeral Home death. Chestertown, MD 21620 death certificate be executed within 24 hours after medical 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, in and completely filled in by to burial, cremation, or remo Approximate shock, or heart fellure. Liet only one ceuse on each line intervai Between **IMMEDIATE CAUSE (Finel Onaet and Death** traumatic event, the Ca of Esophagus with metastasis disease or condition resulting in death) 2 4000 CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF) if any, leading to immediate cause. Enter UNDERLYING signed by the attending physician in Health and Mental Hygiene prior to CAUSE (Disease or injury other DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in deeth) LAST 5 Injury, PART II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part i. 24s, WAS AN AUTOPSY PERFORMED? MEDICAL 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO shows any 1 TES NO COMPLETION OF CAUSE 1 YES 2 NO ō DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: has be Dept. 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) Item certificate I HOSPITAL: 1 TYES 2 NO Inpatient 2 - ER/Outpatient 3 - DOA 4 Nursing Home 5 Residence 6 Other (Specify) of the 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 26d. DESCRIBE HOW INJURY OCCURED with 1 marked, Natural 5 Pending 1 YES 2 NO DIRECTOR: After the hours after death v ₽ 2 Accident 28a. PLACE OF INJURY — At home, farm, street, fectory, offica building, atc. (Specify) 3 Sulcide 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 69 COMPLETED 6 Could not be 4 Homicide 28 determined Hem OR A 29a. CERTIFIER

(Check note)

CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, end due to the cause(s) and menner ee stated. THE HOSPITAL O THE FUNERAL D filed within 72 ho TO THE HOSPITAL
TO THE FUNERAL (
De filed within 72 h
IMPORTANT: If II 2 MEDICAL EXAMINER: On the beals of examination end/or investigation, in my opinion, death occurred at the time, date and placs, end due to the ceuse(s) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER **BE** 29d, DATE SIGNED (Month, Day, Year) 141. When MD. 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Kin Kue Wun Chestertown, MD 21620 31. DATE FILED (Month, Day, Year) Julia Davidson-Randall 7 '95

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

BALTIMORE, MARYLAND 21215-0020	hours after death. Page 6 may be retained by the hospital or attending physician.	is certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	medical examiner must be notified at once.
DIVISION OF VITAL RECORDS, P.O. BOX 68/60	TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within Z4 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the file be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

		FOR 1 STATE	STATE OF I	MARYLAND	/ DEPAI	RTMENT O	F HEALTH	I AND I	MENTAL HYGIEN	E		70042
		REGISTRAR 1. DECEDENT'S NAME (First, Middle, Last)			CERTIF	ICATE (OF DEA	TH	REG. NO			
			les Edga	r Your	kins				NOV. 29	199	5 YEAR	7:15 A. M
		4. SOCIAL SECURITY NUMBER 219-14-7524	5. SEX	8. AGE (In yrs		IF UNDER 1 YE	EAR IF UNDE	R 24 HRS.	T DATE OF BUTTLE		I a province	LACE (State or Foreign
		9a. FACILITY NAME (If not institution, give str	1 X M 2 F	69	YRS.				Mar. 25,			
g	٤	Frederick Memoria		:a1			wn on Locat rederi		EATH	oc. county of de		
3		RESIDENCE OF DECEDENT						CK		r:	reder	ICK
DIRECTOR			ederick			Y, TOWN OR L						IOd. INSIDE CITY LIMITS?
		10e. STREET AND NUMBER	CGCLICK		1	таате	101. ZIP COD	Œ		10g. CIT		I YES 2 NO
FUNERAL		7217 Picnic Woods	Rd.					2176	69	U.S	S.A.	
		11. MARITAL STATUS 1 Never Merried 2 X Married	Never Merried 2 X Married FORCES? 1 YES					OF HISPAN	NIC ORIGIN? (Specify Yes	or No-	14. RACE - Black,	- American Indian, White, etc.
ě		3 Widowed 4 Divorced	IF YES, GIVE Y	AR OR DATES			YES 2 X NO				Specify	White
15. DECEDENT'S EDUCATION (Specify only highest grade completed) 16a. OECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working) 16b. KIND OF BUSINESS/INDUSTRY												
Elementary/Secondary (0-12) College (1-4 or 5+) Truck driver												
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 7 16a. OECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use refered.) Truck driver 10. MOTHER'S NAME (First, Middle, Lest) Charles Elmer Younkins 16a. OECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use refered.) 15b. KIND OF BUSINESS/INDUSTRY 16b. KIND OF BUSINESS/INDUSTRY 16b. KIND OF BUSINESS/INDUSTRY 16b. KIND OF BUSINESS/INDUSTRY 16b. KIND OF BUSINESS/INDUSTRY 17c. FATHER'S NAME (First, Middle, Meiden Surmame) Elsie Naomi Rohrback												
E .		1X Burlat & Cremation 3 Ramov	val from State	cemetery,	cremetory or of the character	i ^{ther} Cemet	erv		12/1 Mid			
examiner	1	21. SIGNATURE OF PUNEAUL SERVICE LICE	RSEE (-	-	22. NAN	E AND ADDRE	SS OF FAC	CILITY			
	ı	MAG 301	WAD	~		31 H	ard b. E. Mair	n St.	npson Funer , Middleto	cal I	nome Md.	21769
200	Ĭ	23. PARK L Enter the diseases, or co ahock, or heart failure. L	omplications that	t caused the	death. Do i	not enter the	mode of dy	ing, auci	h aa cardlec or reapl	retory ar	reat,	Approximate interval Between
E		IMMEDIATE CAUSE (Final							100			Onset and Death
event, the medical		reaulting in death)										
			CH		· C	w 46	-50.0	pate	hearl	131	1000	2 4 2 2 4 3
CERTIFICATION		Sequantially list conditions, if any, leading to immediate cause. Enter UNDERLYING	DUE TO	(OR AS A CON	SEOUENCE O	F):						
Of other traumatic		CAUSE (Disease or Injury that initiated events	DUE TO	(OR AS A CON	SEQUENCE O	F):						
		reaulting in death) LAST										
ر اھ		PART II. Other algnificant conditions	contributing to	death but no	t resulting	In the under	lying cause	given in	Part I. 24a. WAS AN	AUTOPSY	24b. W	PERE AUTOPSY FINDINGS
MEDICAL		EXETABLE		056.			-	ho	PERFOR	MED?	C	MARABLE PRIOR TO COMPLETION OF CAUSE
ME										7		F DEATH?
AN:		DID TOBACCO USE CONTRI	IBUTE TO CA			S NO		ERTAIN	V 🗆			D # []
SICI		EXAMINER?	HOSPITAL:			OTHER:		addanaa	8 Other (Specify)			
PHYSICIAN:		27. MANNER OF OEATH	28a. DATE OF (Month, Di	INJURY	28b. TIM		INJURY AT WORK?	Januarica I	28d. DESCRIBE HOW IN	JURY OC	CURED	
BY PH		Netural 5 Pending 2 Accident Investigation		er mit.		M 1	YES 2	NO				
		3 Suicide a Could not be 4 Homicide determined	28e. PLACE Of building,	F INJURY — At etc. (Specify)	home, farm,	street, factory,	offica		28f. LOCATION (Street e City or Town, State)	nd Number	r or Rural Rou	ite Number,
LET I	1	29a. CERTIFIER CERTIFYING PHYSICI	AN: To the heat of	mu knowledge	death seems	4-44-4						
= 🕏		(Check only one) 2 MEDICAL EXAMINER:							to the cause(a) and man time, date and place, end			nd manner as stated.
BE CO!		296. SIGNATURE AND TITLE OF CERTIFIER						ENSE NUM				fonth, Day, Year)
10 8		TO NAME AND ADDRESS OF	2	_			D14	626		> 1	11/29	/95
-		30. NAME AND ADDRESS OF PERSON WHO Dr. P. Gregory R:					E	do	al- 161 Or	1701		
	-	Dr. P. Gregory Ra	auscii	JIU W.	pever	ILII DE	, rre	der10	ck, Md . 2.	r/OT		

32. REGISTRAT S SIGNATURE

Saucher Reveal

DEC 0 4 1995

TO BE COMPLETED BY FUNERAL DIRECTOR

examiner must be notified at once. TO BE COMP	IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION
examiner must be notified at once.	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
reference director, page 5 should be detached	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in with the state pept, of Health and Mental Hygiene prior to burial, cremation, or removal.
ar death Page 6 may be retained by the hosp	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours man share the season of many be retained by the hosp

1 - STATE REGISTRAR	STATE OF MARYL	AND / DEPARTI			MENTAL HYGIEI	17					
1. DECEDENT'S NAME (First, Middle, Lest) MATT	IES. ALE	XANDE	ER		2. DATE OF DEATH MONTH	3 192	3. TIME OF DEATH				
219-38-8805 1	□ M 2 🛛 F	85 YRS. M	IF UNDER 1 YEAR ONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year)		BIRTHPLACE (State or Foreign Country)				
90. FACILITY NAME (If not institution, give street Bon Secures RESIDENCE OF DECEDENT	HOSpital	n	Balfir	r location of de	EATH	9c. COUNTY	VA				
10s. STATE 10b. COUNTY	IA		altimor	4			10d. INSIDE CITY LIMITS? 1 YES 2 \(\text{NO}\) NO				
100. STREET AND NUMBER 101. ZIP CODE 109. CITIZEN OF WHAT CO 21267 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECEMBENT OF HISPANIC ORIGINAL (SPECIAL VAN OR NO.) 14. BACK - ARMED											
11. MARITAL STATUS 1 Never Married 2 Married 3 Wildowed 4 Divorced 12. WAS DECEDENT EVER IN U.S. ABMED FORCES? 1 YES 2 MO If YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Maxican, Puerto Rican, etc.) 14. RACE — American It yes, specify Cuban, Maxican, Puerto Rican, etc.) 1 YES 2 NO Specify: Specify: Black											
ts. DECEDENT'S EDUCATI (Specify only highest grade con Elementary/Secondary (0-12)		180. DECEDENT'S US (Give kind of wor life. Do NOT use I	rk done during mo retired.)	ON st of working	166. KIND OF BU	JSINESS/INDUS					
17. FATHER'S NAME (First, Middle, Last) Thomas Kobinsu		nevar a	7071-	18. MOTHER'S NA	ME (First, Middle, Maide	n Sumame)					
Donald Odo	ns	196. MAILING AI	Lyons	1 1	Poute Number, City or To	Ow, Ng	5 Mills 24				
20e. METHOD OF DISPOSITION 1	from State	PLACE AND BATE OF	YEM /	tark	12/18/45 KC	endal	or Town, State				
21. SIGNATURE OF FUNERAL SERVICE LICENS Lange Lan	Wane	ر د	Yary	DADDRESS OF FA	Walash	Le	Balto, nd				
23. PART I. Enter the diseases, or com- shock, or heert feilure. Liet IMMEDIATE CAUSE (Finei disease Dr condition resulting in death)	CARPLA	the death, Do not ach line. CONSEQUENCE OF:		de of dylng, suc	h as cardiac or rea	piretory arrest	Approximata Interval Between Onset and Daath MINITES				
Sequentielly list conditions, b	RESPIRA		n) Free	ENCY			13 1045				
if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events	BILLTER DUE TO (OR AS A	AL PURE			•		13 0045				
resulting in deeth) LAST	INFILTRA						MONTHS.				
PART II. Other algnificant conditions of ASCVD HYPE NON INSULIA DID TOBACCO USE CONTRIB	DEPENDAN	E DISEAUT DIAB	eres	MELLITIS.	1 PERFO	RMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO				
25. WAS CASE REFERRED TO MEDICAL EXAMINER?		26. PLACE OF DEATH	(Check only one)								
27. MANNER OF DEATH 1 Netural 5 Pending	28e. DATE OF INJURY (Month, Day, Year)	28b. TIME I	DF 296. INJ		6 Other (Specify) 28d. DESCRIBE HOW	INJURY OCCUR	ED				
2 Accident Investigation 3 Suicide 8 Could not be determined 28s. PLACE OF INJURY — Al home, farm, street, uctory, office City or Town, State) 28s. LOCATION (Street and Number or Rural Route Number, City or Town, State)											
(Orlock Orly)	(Check only										
7	SIGNATURE AND TITLE OF SENTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) 12.14.95										
30. NAME AND ADDRESS OF PERSON WHO CE RUESTO MO LEIA	OMPLETED CAUSE OF DE	ATH (ITEM 27) (Typo, P 450 ELUC	OTT CEN	TER DR.	SUITE 105	- Elli	21043				

Item1 12-15-95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible

State of Maryland / Department of Health and Mental H

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Physician /Medical Examine			1. Decedent's Nam	,	, Last) Hibbons	Amor	Mar	y Jo	Gibbor	is Ame	r	2. Date of Do Month Dec	Day	Year	Time of Death 5:30 p
Ŧ			4e. Fecility Neme (/	If not Institution	, give street and i	number)				4b. City, T	own, or L	ocation of Deal	h 4c. County	of Death	
			81 Beac	h Hill						Ocea	an C	ity	Word	ester	
Ī	Funeral Director		5. Sociel Security N 212-28-		6. Sex 1 □ M 2√√F		(In yrs. last bi	rthday) Yrs.	If Under 1 Yea Months Dey		Min.	8. Dete of Bi (Month, D) Nov	rth L8,1928	9. Birthpiace Country)	(State or Foreign
Н	ש		Usual Residence of	Decedent											110
	death with the Meryland ma 23a or 28a-f show f must be notified at		10a. State	10b. County			10c. City, Tow	m or Loc	cation					10d.	Inside City Limits
	Me I	to	Md	Worce	ester		Oce	an	City						1 □Xes 2 □ No
	1384 In	9	10e. Street and Nur	mber					10f. Zip Code				10g. Citizen of \	What Country?	
	with w	ō	81 Bea	ch Hil	1				2184				-	SA	
	a 23	era		- 1111		or to II O	140.14			1-1-0 (0				la dia	
		Funeral Director	11. Maritel Stetus 12. Wes Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Ricen, etc.)							Bia	e - American f ck, White, etc.				
20	72 hours effer death with the Merylar natural", or fierra 23e or 28e-f show 3 cell Experience route be notified at	by F		1 ☐ Never Married 2 Merried 1 ☐ Yes 2 ☐ No If Yes, Give 1 ☐ Yes 2 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:									Specify	<i>(</i> :	
21215-0020		d D	3 Li Widowed			r Dates:								whi	
5	72 h	Completed	(Spec	15. Decedent cify only highes	's Education It grade complete	d)	16a	. Decede (Give k	ent's Usual Occi kind of work don 30 NOT use retii	upation e during mo	st of work	king	16b. Kind of B	usiness/Indust	ry
21	within ene.	ig.	Elementary/Seco		T	9 (1-4or 5+)	life. D	O NOT use retir	red)					
	A De La	Ö	12		4			Exe	cutive				Oil F	Retail	Bus.
pu	# fe fe	Be	17. Father's Name		*					18. Moth	er's Nam	e (First, Middle	, Maiden Surnan	10)	
a	Alenta Ked	To	James	P. Gik	bons					He:	len	J. Mcl	Mahon		
Maryland	2 should be filled within end Mental Hyglene. Is marked other than raumatic avent, the Mental than the manufacture of the Mental than the Men		19a. Informant's Na	ame/Relationsh	nip (Type, Print)		198	. Mallin	g Addrass (Stre	et and Numi	ber or Rur	ral Routa Numb	per, City or Town,	State, Zip Con	de) 21046
Σ	ges 1 and 2 should be filed within 72 hr to Health and Mental Hyglene. If item 27 is marked other than "nature or other traumatic avent, the Medical		Mary Os	hourne			1								Md 218
တ်	Hea Hea		20a. Method of Disp		<u>- </u>		20b. Place o	f Dispos	ition (Neme of		rage	Date	20c. Location		
ō	T H Dor or or				3 □Removai fro	m State	cemete	ry, crem	etory or other p						
Baltimore,	permit. Peges 1 end 2 Department of Health e Important: If item 27 is any Injury or other tra once.		4 ☐ Donation	5 Other (Sp	ecify)		New C	ath	edral	Cem.	1	2/14	Baltim	ore,	Md.
ā	Departimon Important In Doce.		21. Signature of Fu	inerei Service I	icensee			22.	Neme end Add	ress of Faci	lity	Fune	ral Hom	10	
m)	205 2 2		N. t.	1 /2 1	doleta			_		_			, Balto		21228
			23a. Part1. Enter the shock, or haar	he disease, or	complications tha		he death. Do							Api	proximate
	Dhamistan		shock, or haa	rt fallure. List	only ona cause or	n each line).			, ,		, , , , ,		Inte	arval Between
3	Physician / /Medicai		Immediata Causa (/Final			1	-	0110	m . A		10			2/0-
	Examiner		disease or condition	n	Θ		LUN	Q	CANCE	R				10	175
н		2	,			D	ue to (or as a								
	Sit 9d	Examiner			b	CIGARET SMOKING									
	and tran	can	Sequentially list con	nditions,		Due to (or as e consequence of):									
68760,	certificate be executed nding physician and use as the buriel-transit		Sequentially list con if any, leading to im- cause. Enter Unde Cause (Disease or that initiated events	erlying			CHRONIC OBSTRUCTIVE					I WAS DISEASE			
376	ate b nysic he b	lica	that initiated events resulting in death) I	ast	Due to (or es e consequence of):									1	
9	DO P	n/Medical	recently in security is	100											
X	andir use	١	d												
B	law requires that the death iss been signed by the atter 2 should be detached for i	Physicia	Part fl. Other elgoit	Other signiffcant conditions contributing to death but not re					deriving cause of	iven in Part	1	23h Did	tobacco use co	ntribute to the	cause of death?
P.O.	the y the	λ	TOTAL OTHER SIGNA	TOUR CONTENT	ne contributing to	Godin Dui	not resulting i	ii uio uii	derlying cause (jivon in ran	1.				
	that ed b	P /										16	Yas 2□ No	3 Probabi	ly 4 Unknown
of Vital Records,	signed I	d by										Ode Me	s an autopsy	24h Wara	autopsy findings
Ö	v require been si should	Completed											ormed?	availab	ole prior to etion of cause
ec	has t	d												of deat	
<u>—</u>	The la	ő										10	Yes 2 No	1 □ Ye	s 2 No
E	certificate rector, pag	Be (25. Was case refer	red to medical						26. Plac	e of Deat	th (Check only	one)		
>	Physician: this certific ral director,	ToE	axaminar?	NO	Hospital:] fnpatien	2 ER/O	utpatient	3□ DOA C	ther: 4 N	iursina Ha	me 5 Hes	Idence 6 □Oth	er (Specify)	
0	£ 5 8		27. Manner of Death	h		te of Injury onth, Day		Time of	28c. Inj				how fnjury occur		
Division	or Attending Phefier death. Director: After the in by the funeral	Certification:	1 ☑Natural 2 ☐ Accident	5 Panding investig		onth, Day	Year)	Injury		ork? ⊒Yes 2.⊑	No				
S	or Attendii efter death. Director: A I in by the fu	Ica	3 ☐ Suicide	6 ☐ Could n	ot be	ce of Injur	v - At home fo	arm etro	et, factory, office	9		28f 1 ocation	(Street and Numb	ner or Rural Br	rute Number
Š	P # 7 =	Ē	4 Homicida	determi	ned bui	iding, atc.	(Specify)	aiii, aiio	ot, factory, office	9			wn, Stata)	or or riorar rio	oto rvanibo.,
ш	Hospital or Attending 24 hours efter death. Funeral Director: After stely filled in by the fune														
	to the firms	Ca	29a. Certifier (Check only	1 ☐ Cartifying	Physician: To the examiner: On the	he best of besis of e	my knowledge examination an	e, death	occurred at the estigetion, in my	time, date a	nd place, ath occur	and due to the	cause(s) and ma	anner as stated	d. cause(s)
	To the Hospital within 24 hours To the Funeral completely filled	Medical	one)												
Dullding, atc. (Specify) 29a. Certifier (Check only one) 29b. Signeture and title of certifier 29b. Signeture and title of certifier									nse number			29d. Date signe	d (Month, Day	, Year)	
						0		./	1278	43		12/11	195		
1			30. Nama and addre	es of person	vho completed co	usa of day	th (Item 23a)	(Type D		0,1			1		
1	10/		77:	6011											
			31. Date flied (Mont	th Day Year	J . 1/4	Begletre	TR M Is Signature Lear Rand	' (/			_				
	Sta		DEC		DE (1)	Aust	Lear Rand	all							
	Registr	aı	DEC	T 9 193	13 Om	*			_						

DIVISION OF VITAL RECORDS, P.O. BOX 68769

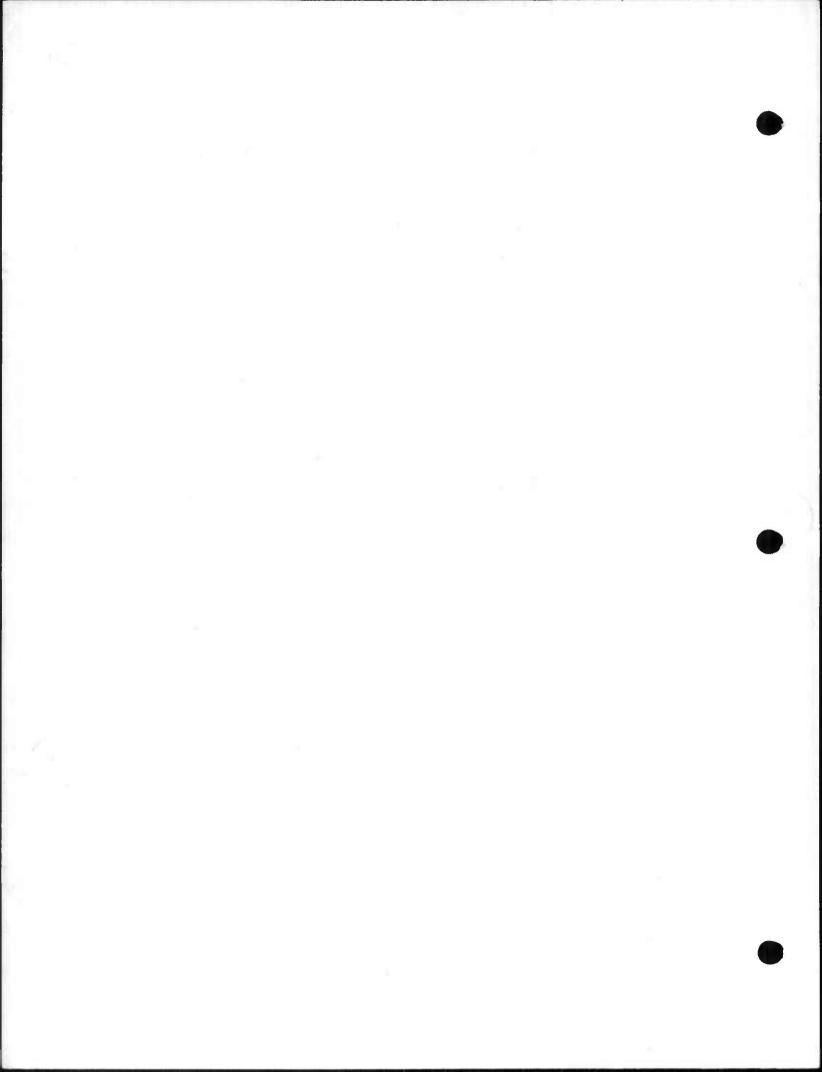
attending physician. use as the burial-transit permit. Pages 1, 2, 3 should

ALTIMORE, MARYLAND 21215-0020

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL	HYGIENE
CERTIFICATE OF DEATH	REG. NO.

	1 - STATE REGISTRAR	STATE OF MARYL		RTMENT OF		MENTAL HYGIEN			
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH		3. TIME OF DEATH D	
1	Wilbur I F	Bandv				Dec. 11	1995	1:00 M	
	4. SOCIAL SECURITY NUMBER		(In yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH	8. BIR	ITHPLACE (State or Foreign	
	213-68-9686	1X M 2 □ F 6	58 YRS.	MONTHS DAYS	HOURS MIN.	July 15,	27 N	Maryland	
	9a. FACILITY NAME (If not institution, give	street and number)		96. CITY, TOWN	OR LOCATION OF DE		9c. COUNTY OF DEATH		
6	8209 Watersedo	ge Road		Dund	la1k		Balt	imore	
HESIDENCE OF DECEDENT 10c. CITY, TOWN OR LOCATION 10d. STATE 10d. COUNTY 10d. STATE 10d. COUNTY 10d. CITY, TOWN OR LOCATION 10d. CITY, TOWN OR LOCATION								10d, INSIDE CITY	
							LIMITS?		
	104. STREET AND NUMBER				f. ZIP CODE		10a. CITIZEN OI	1 YES 2 XNO	
FUNERAL	8209 Watersedg	ge Road			21222		U.S.A		
5	11. MARITAL STATUS	12. WAS DECEDENT EVER I	IN U.S. ARMED	13. WAS DE	CENDENT OF HISPAN	IIC ORIGIN? (Specify Yes	or No- 14. RA	ICE — American Indian,	
BY F	1 Merried 2 Merried 3 Widowed 4 Divorced	FORCES? 1 YES			pecify Cuban, Mexical S 2 X NO Specify	n, Puerto Ricen, etc.)		eck, White, etc.	
		1						ite	
COMPLETED	15. OECEDENT'S EDU (Specify only highest grade	le completed)	16a. DECEDENT'S (Give kind of v life. Do NOT us	WORL OCCUPATI	ON ost of working	16b. KINO OF BUS	SINESS/INDUSTRY		
1 2 1	Elementary/Secondary (0-12)	College (1-4 or 5+)	1	oloyed		N/A			
8	17. FATHER'S NAME (First, Middle, Lest)	-	_ onemp	ziojea	18. MOTHER'S NA	ME (First, Middle, Maiden	Sumemel		
	John H. Bandy					lizabeth			
) BE	19a. INFORMANT'S NAME (Type/Print)	<u></u>	19b. MAILINO	AOORESS (Street	and Number or Rural F	Route Number, City or Tow	n, State, Zip Code)		
임	Gloria Stumpf		8209	Waters	edge Rd	.,Balto.	, Md. 2	1222	
	20a. METHOD OF DISPOSITION 1X Burial 2 Cremetion 3 Ram		b. PLACE AND DATE O		eme of	OATE 20c. LO	CATION — City or	Town, State	
	4 Donation 6 Other (Specify)	F	parkwood	Cemet	erv 12	-14-95	Balto.	. Md.	
	21. SIGNATURE OF FUNERAL SERVICE LI	CENSEE		22. NAME A	ND ADDRESS OF FA	nton Fune		21222	
	Ptulles	Tailes				Spring			
	23. PART I. Entar the disesses, or	complications that cause List only one cause on a	d the deeth. Do n	not anter the mo	ode of dylng, auci	ss cardiac or respi	ratory arreat,	Approximate	
	IMMEDIATE CAUSE (Finel	100000000000000000000000000000000000000						Interval Between Onset and Death	
	disease or condition resulting in death)	a. Arrhyth	mia v	s. M1				minutes.	
					, .			10	
NO	Sequentially list conditions,	b. Congenit	al Min	tal Ren	taidatio	w		>60 yrs.	
ĕ	If any, leading to immediate cause. Enter UNDERLYING	DOLJO (ON AS .	T CONSEQUENCE OF	ŋ.					
필	CAUSE (Disease or Injury that Initiated events	DUE TO (OR AS	A CONSEQUENCE OF	ŋ:					
CERTIFICATION	reaulting in deeth) LAST	d							
0									
	PART II. Other significent condition	ns contributing to deeth b	out not resulting i	n the underlyin	a cause alven in	Part I 24- ME AN	ALITOPICY O	AL MERE AUTORON FRANCISCO	
8	PART II. Other significent condition	ns contributing to deeth t	out not resulting i	in the underlyin	g cause given in	PERFOR	MED?	4b. WERE AUTOPSY FINDINGS MAILABLE PRIOR TO COMPLETION OF CAUSE	
	PART II. Other significent condition	ns contributing to deeth t	out not resulting i	in the underlyin	g cause given in		MED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?	
MEDIC						PERFOR	MED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE	
MEDIC	DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL			s 🗆 no 🖸		PERFOR	MED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?	
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BY PHYSICIAN: MEDIC	DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending Investigation	RIBUTE TO CAUSE C HOSPITAL: 1 Inpetient 2 ER/Out 28a. DATE OF INJURY (Month, Dey, Year) 28a. PLACE OF INJURY	DF DEATH YE 26. PLACE OF DEAT petilent 3 DOA 28b. Timelin, in, in, in, in, in, in, in, in, in,	S NO S TH (Check only one) OTHER: 4 Numling Hon E OF 28c. IN. URY M 1	UNCERTAIN 10 5 Phaeldenca UURY AT PKS 2 NO	PERFOR 1 YES 2 6 Other (Specify) 28d. DESCRIBE HOW II Dur /	NJURY OCCUREO	AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO	
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DHMH-18 Ray 1/89

permit.

page 5 should be detached for use as the burial-transit

director,

completely filled in by the funeral

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cremation,

burial,

and

attending physician

en signed by the attending physician a of Health and Mental Hygiene prior to

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certificate

the State Dept.

with this

L DIRECTOR: After the bours after death v

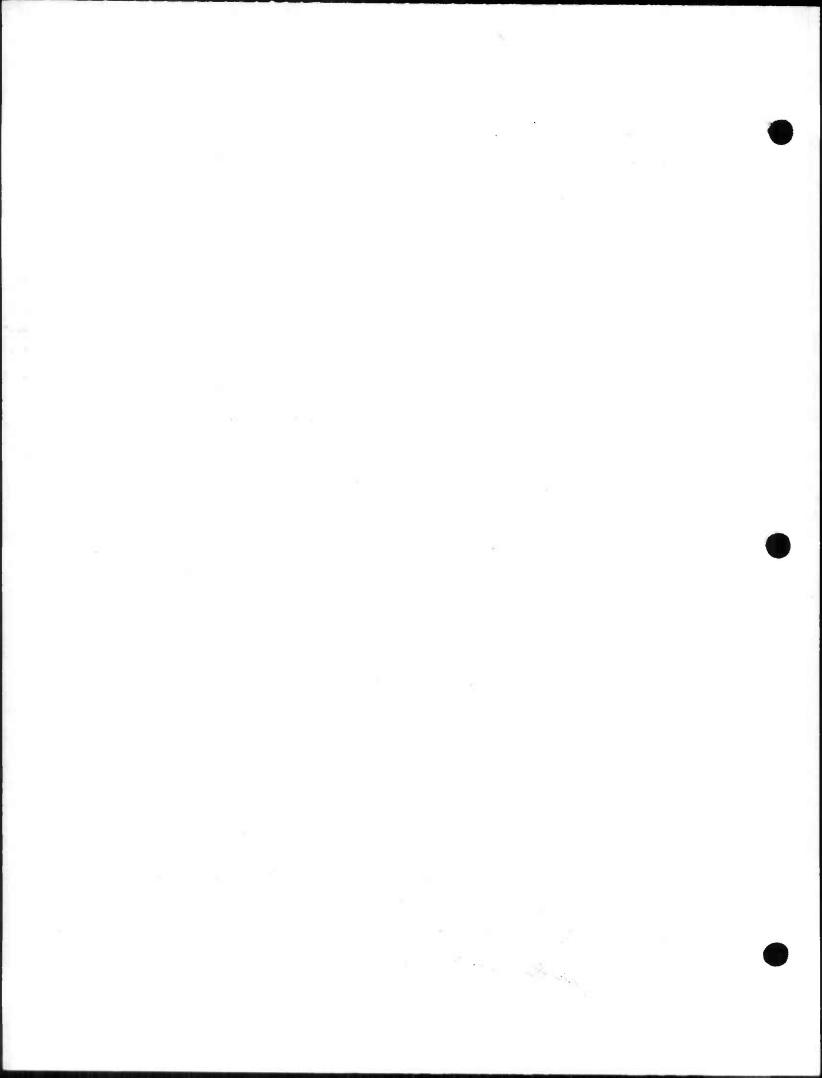
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1 - STATE REGISTRAR **CERTIFICATE OF DEATH** 2. DATE OF DEATH MONTH 1. DECEDENT'S NAME (First, Middle, Last) 3. TIME OF DEATH Ethel 8:31 Brooks 995 December 6. AGE (In vrs. lest birthdev) 7. DATE OF BIRTH (Month, Day, Year) 4 SOCIAL SECURITY NUMBER IF UNDER 1 YEAR 8. BIRTHPLACE (State or Foreig IF UNDER 24 HRS. 217-12-9833 DAYS HOURS MIN. 1 M 2 X F Maryland APr.21 924 9c. COUNTY OF DEATH Sa. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH Burnie North Arundel Anne Arunde HOSDITA DIRECTOR 10a. STATE 10c. CITY, TOWN OR LOCATION 10b. COUNT 10d. INSIDE CITY Md. Anne Arundel Glen Burnie 1 YES XIX NO 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? FUNERAL 90 Foxwell Bend Rd. 21061 U.S.A. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 14. RACE — American Indian, Black, White, etc. 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-1 Never Married 2X Married If yes, specify Cuban, Maxican, Puarto Rican, etc.) 1 TES 2 NO Specify: Specify: В 3 Widowed 4 Divorced White 18a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) COMPLETED 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade comp. Elementary/Secondary (0-12) College (1-4 or 5+) 12 Own Home Homemaker 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) James Horton notified at Evelyn Weyman 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Philip E. Brooks 90 Foxwell Bend Rd., Glen Burnie, Md. Pe 20a. METHOD OF DISPOSITION
1 Daylei 2A Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION — City or Town, Stata must Chesapeake Crematory

Chesapeake Crematory 12-14-95 Beltsville Md 21222 con Funeral Home, Inc. 4 Donation 6 Other (Specify) examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Bradley-Ashton Funeral Ho
2134 Willow Spring Rd., Ba

23. PART I. Enter the decases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Bradley-Ashton Funeral Home, 2134 Willow Spring Rd., Balto., Md. medical Approximate Interval Between Onset and Death shock, or heart fallure. List only one cause on each line IMMEDIATE CAUSE (Final the disease or condition DUE TO (OR AS A CONSEQUENCE OF): lo Clay (resulting in death) other traumatic event, FRONIC OBSTAUGHOR PULMONARY DISEASE ean CERTIFICATION Sequentially list conditions, if any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF) DUE TO (OR AS A CONSEQUENCE OF): cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events NEUMON'A reaulting in death) LAST 10 Injury, PART II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY 24b. WERF AUTOPSY FINDINGS AhrumaToi) AWAILABLE PRIOR TO COMPLETION OF CAUSE FIBALLIATION, ANTHAIRS shows any 1 YES 2 NO OF DEATH? 1 TYES 2 NO PHYSICIAN: DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 23 25. WAS CASE REFERRED DO MEDICAL 26. PLACE OF DEATH (Check only one) Item HOSPITAL EXAMINER? OTHER: 1 YES 2 NO Inpetient 2 - ER/Outpetient 3 - DOA 4 Nursing Homa 5 Residence 8 Other (Specify) 6 28a. DATE OF INJURY (Month, Day, Year) 27. MANNER OF DEATH 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED marked, 1 Natural M 1 YES 2 NO ВҰ Investigation 2 Accident 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 28e. PLACE OF INJURY — At home, ferm, street, factory, office building, etc. (Specify) 3 Suicide 28 ls 6 Could not be COMPLETED 4 Homicide Item 2 29a, CERTIFIER CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as atated. TO THE HOSPITAL D TO THE FUNERAL DI DE filed within 72 ho IMPORTANT: If 116 2 MEDICAL EXAMINER: On the 28 2 2 2 / 29d, DATE SIGNED (Month, Day, Year) BE 2 WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) M) 301 HOSPIFAL DAIVE CLENBURNIE, MANYCAND schneusfeller 32. REGISTRAR SCIGNITURE

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the bospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

1 - STATE

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAN				CENTIF	ICAL	LUI	DEA	111	P	REG. NO.				
	1. DECEDENT'S NAME (First	, Middle, Last)								2. DATE OF MONTH	DEATH		YEAR	3. TIME OF DEATH	
	Charles				BURK	JRKMAN Sr.			December 11, 1				2:28 p M		
	4. SOCIAL SECURITY NUME		5. SEX	6. AGE (In yrs.		IF UNDE	R I YEAR	IF UNDER	_	7. DATE OF BIRTH (Month, Day, Year)			8. DIRTH	PLACE (State or Foreign	
	216-09-78	-09-7818 1X M 2 □ F 8				MONTHS	DAYS	HOURS MIN.		4-28	3 – 1 4		Country	MD	
	9a. FACILITY NAME (If not in	stitution, give :	street and number)		4	9b, CIT	Y, TOWN	OR LOCATI	ON OF DE			9c. COU	NTY OF DI		
۳ ا	Franklin Square Hospital						P.	ossvi	110			D - 1	+ -i	un Country	
읽	RESIDENCE OF DEC			-			1/(J55VI	ille			Dal	LIMOI	re County	
DIRECTOR	10a. STATE	10b. COUNT			10c. CIT	0c. CITY, TOWN DR LOCATION 10d.						10d. INSIDE CITY LIMITS?			
5	MD		Baltimor	e		Ro	seda	ale						1 YES 2 T NO	
ᇦ	10e. STREET AND NUMBER						10	f. ZIP COD	E			10g. CITIZEN DF WNAT COUNTRY?			
	7921 Un					21:	237		,	USA					
FUNERAL	11. MARITAL STATUS		12. WAS DECEDEN	T EVER IN U.S.	ARMED	13.	WAS DEC	CENDENT C		IC DRIGIN? (S	ipecify Yea			American Indian,	
	1 Never Married 2 🗓	Married	FORCES? 1	YES 2	Мио		If yee, sp	ecity Cube	n, Maxica	n, Puerlo Rica	n, etc.)		Black	, White, etc.	
B	3 Widowed 4 Divo	proed	W 123, GIVE V	MR ON DATES			1 [163	2 NAO	эресну	ï			Specif	w white	
		EDENT'S EDU		16a.	DECEDENT'S	USUAL C	CCUPATI	DN		16b. KII	NO OF BUS	INESS/IN	DUSTRY		
COMPLETED	Elementary/Secondary (y highest grade	College (1-4 or 5		(Give kind of life. Do NOT u	work done se re tired.)	during mo	ost of working	ng						
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8	17. FATHER'S NAME (First, M	fiddle, Last)						16. MOT	HER'S NAI	ME (First, Midd				001	
O U	(unk.)								Anna	(11	nk.)				
0	19a, INFORMANT'S NAME (Type/Print)			19h MAILING	Annees	S /Street	1		Route Number,		State 7	in Corte		
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	204, METHOD OF DISPOSIT	TON		001.014					na.	DATE	v -		2123		
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	21. SIGNATURE OF FUNERA		CENSEE	- dar	delis			ND ADDRE			Ва	Ltime	ore,	MD	
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IMMEDIATE CAUSE (Finel disease or condition resulting in death) Sequentially list conditione, if eny, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in-death) LAST LATER A CONSEQUENCE OF): Due to (OR AS A CONSEQUENCE OF):					Interval Batween Onset and Death 40 years										
EDICAL										1	PERFOR			COMPLETION OF CAUSE OF DEATH?	
MEL														1 YES 2 NO	
	DID TOBACCO L	JSE CONT	RIBUTE TO CA	USE OF D	EATH Y	ES 🔲	NO E	J UNC	CERTAIL	1					
PHYSICIAN:	25. WAS CASE REFERRED 1				LACE OF DEA										
Sic	EXAMINER?		HOSPITAL:	X ER/Outpetien	1 3 DOA	OTHE		ne 5 🗆 R	asidenca	6 Other (S	pec/fv)				
ا ب	27. MANNER OF DEATH		26a. DATE OF	INJURY	26b. TII	AE OF	28c. IN.	JURY AT		28d. DESCR		NJURY O	CCURED		
		Pending	(Month, E	ley, Year)	- IN	JURY		ORK? YES 2 [NO						
ВУ	2 Accident 3 Suicide	Investigation	26a. PLACE C	F INJURY — A	t home, farm,	street, fac	ctory, offic	ca		26f. LOCATII	DN (Street a	nd Numbe	er or Rural F	Route Number,	
	4 Homicide	Could not be determined	building	atc. (Specify)						City or 1	own, State)				
9	29a. CERTIFIER			7.79.00		H LSeb M									
COMPLETED	enal cing		BICIAN: To the best of												
ᅙ			1	/	vor investigati	on, in my	opinion,	death occu	ired at the	time, data an	d placa, an	d dua to t	he cause(s	and manner as stated.	
BE	296. SIGNATURE AND THE	DI CERTIFIE	M/10. /1	1				29c. LIC	ENSE NUR	MBER		29d. DA	TE SIGNED	(Month, Day, Year)	
	(00 1)	1)	ww U)			D2	7315			- /	27	(-75	
임	30. NAME AND ADDRESS D	F PERSON W													
	M.L. Fryden	borg,		00 Fraj		Squa	re I	rive	, B	altimo	ore,	Mar	ylan	d 21237	
	31, DATE FILED (Month, Day,	Year)	32 REGISTR	AR'S SIGNATUR	VE.										
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	to all 4													DHMH-16 Rev 1/89	



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middle, Last) 2. Dete of Death 3. Tima of Death **Physician** Month John Т. Bolte 7:25P 12 /Medical 4e. Facility Name (If not institution, giva streat and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner 207 E. Medwick Garth Baltimore Catonsville 7. Age (In yrs. last birthday)

| If Under 1 Year | If Under 24 Hrs. | 8. Dete of Birth (Month, Dey, Year) | 6 / 7 / 2 8 5. Social Security Number Birthplace (Stata or Foreign Country) **Funeral** 187-22-7957 10 M 2 F Director Pennsylvania Usual Rasidence of Decedant the Meryland 10a. State 10b. County 10c. City, Town or Location 10d. insida City Limits 28a-f ahow permit. Pages 1 and 2 should be liled within 72 hours after deeth with the Meryla Department of Health and Mentel Hygiene. Important: If Item 27 is marked other than "naturel", or items 23a or 28a-f show any injury or other treumetic event, the Medical Examiner must be notified at price. Maryland Baltimore Catonsville 1 ☐ Yes 2 No Director 10e. Street end Number 10f. Zip Coda 10g. Citizan of Whet Country? 21228 207 E. Medwick Garth U.S.A. Funeral 12. Was Decedant Evar in U,S. Armed Forces? 1 M Yas 2 M No If Yas, Giva Yeer or Datas:1949—1951 13. Was Decedant of Hispanic Origin? (Specify Yas or No If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Amarican Indien, Bleck, White, atc. 1 Nevar Merried 2 Married Barlimore, Maryland 21215-0020 1 ☐ Yas 2 ☐ No Specify: þ Specify: White 3 Widowed 4 Divorced Completed 16a. Decedant's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT usa ratired) 15. Decedant's Education (Specify only highast grade complated) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Coilaga (1-4or 5+) Truck Driver Carolina Freight Company 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middle, Malden Surnama) Be Joseph F Bolte Stella M. McCollough 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Bolte 207 E. Medwick Garth Catonsville, Maryland 21228 20b. Place of Disposition (Nama of cemetery, cramatory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata 1 ☒ Burial 2 ☐ Crametion 3 ☐ Ramovai from State Baltimore National Cemetery Dec. 18, 1995 Baltimore, Maryland 4 ☐ Donation 5 ☐ Othar (Specify) 22. Name end Addrass of Facility Leroy M. & Russell C. Witzke Funeral Homes 21. Signeture of Paneral Service License 1630 Edmondson Avenue Catonsville, Maryland 21228 23a. Party Entar the disease, or complications that caused the death. Do not antar the mode of dying, such as cardiac or raspiratory arrest, shock, or heart failure. List only one cause or much line. Onset end Deeth Physician Respiratory Failer 2° to Metastatic Lung CA /Medical Immediata Causa (Final 10 mo diseese or condition resuiting in daeth) Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying Cause (Disease or Injury that initiated events rasulting in death) Last Due to (or as a consequence of) physician is the bunal Division of Vital Records, P.O. Box 68760 Physician/Medical Dua to (or as a consequence of): signed by the at id be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 | Yes 2 | No 3 Probably 4 □ Unknown by 24a. Wes an autopsy performed? 24b. Were autopsy findings available prior to Completed evallable prior to completion of cause of death? 1 □ Yas 2 No certificate 1 Yas 2 No 25. Wes casa rafarred to medical examiner? Be 26. Placa of Death (Check only ona) 1 Yes 2 No Other: 4 Nursing Home 5 Rasidance 6 Other (Specify) 2 1 Inpatiant 2 ER/Outpatient 3 DOA 28a. Data of Injury (Month, Day Year) 27. Mannar of Death 28b. Tima of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Panding eftar death. 2 Accidant 1 Yas 2 No invastigation 6 Could not be detarmined 3 Suicida 281. Location (Street and Number or Rural Route Number, City or Town, Stata) 28e. Place of Injury - At home, farm, streat, factory, office building, etc. (Specify) 4 Homicida To the Hospital of within 24 hours a To the Funeral D completely filled in 12 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and dua to the causa(s) and mannar as stated.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and mannar stated. 29a. Cartifiar Medical 29b. Signetura and Jitla of certifian 29d. Data signed (Month, Day, Year) M.D wara R D39834

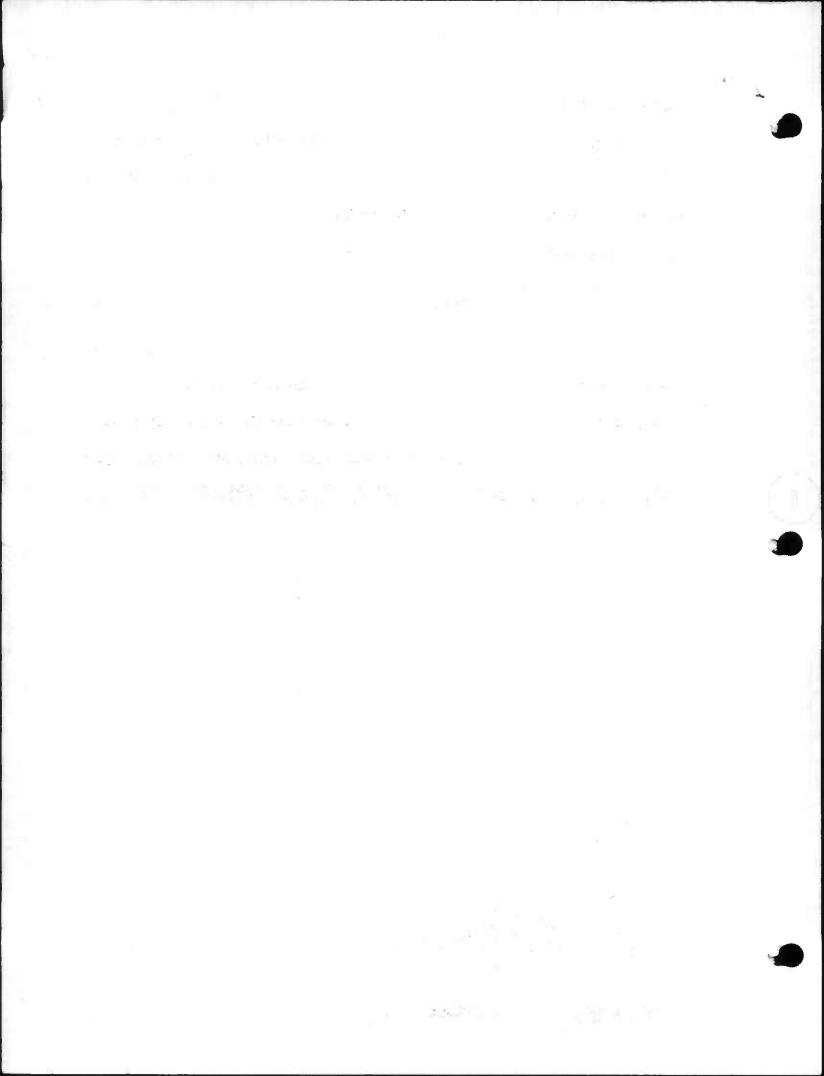
ens Avenue -

State Registrar 30. Nama and addrass of person who complated the

31. Data filed (Month, Day, Yaar)

DEC 1 5 1995

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 min. The HOSPITAL OR PITENDING PHYSICIAN: The law requires that the death certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

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	FOR STATE REGISTRAR	STATE OF MARY		TMENT OF H		MENTAL HYGIEN	-		
	1. DECEDENT'S NAME (First, Middle, Last)		OLITIII	OAIL OI	DEATH	2. DATE OF DEATH		3	. TIME OF DEATH
U		Alma Or	lotha B	1107		MONTH C		YEAR	3:55p
	4. SOCIAL SECURITY NUMBER		(In yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	Dec. U			ACE (State or Foreign
		1 🗆 M 2 🔛 F	1000	MONTHS DAYS	HOURS MIN.	(Month, Day, Year)		Country)	
1	217-16-0428		83 YRS.			03-18-1			sissippi
~	9e. FACILITY NAME (If not institution, give a				OR LOCATION OF DE	EATH	9c. COUNT	Y OF DEA	TH
DIRECTOR	926 N. Payson	Street		Balt	imore		N/	A	
<u>[</u> [10e. STATE 10b. COUNTY	1	10c CIT	f, TOWN OR LOCA	TION			1/	0d. INSIDE CITY
<u> </u>	MD. N	Τ / Λ							LIMITS?
1 1	10e. STREET AND NUMBER	1/A			imore		40 - 017475		TYES 2 NO
FUNERAL				10			10g. CITTZE	IN OF WH	AT COUNTRY?
R	926 N. Payson				21217			U.S.	·
5	11. MARITAL STATUS 1 Never Married 2 Married	12. WAS DECEDENT EVER FORCES? 1 YES	27 NO	If yes, sp	ecify Cuben, Mexica	HC ORIOIN? (Specify Yen, Puerto Riceri, atc.)	e or No 1	Black, V	- American Indian, White, atc.
B≼	3 ₩ Widowed 4 Divorced	IF YES, GIVE WAR OR I	DATES	1 TYES	2 NO Specify	r		Specify:	Black
0	15. DECEDENT'S EDU	CATION	16a. DECEDENT'S	UPLIAL OCCUPATA	ON	16b, KIND OF BL	ICINICOS (INICII)	OTEN	
	(Specify only highest grade	completed)		vork done durina ma		166. KIND OF BC	SINESS/INDU	SINT	
12	Elementary/Secondery (0-12)	College (1-4 or 5+)				0			
COMPLETE	17. FATHER'S NAME (First, Middle, Last)		Nurse	-	14 MOTHER'S NA	ME (First, Middle, Meider	Comment		
	Edgar Pittman								
H	19e. INFORMANT'S NAME (Type/Print)		10h MAII ING	ADDRESS (Street		ine Tho		lada)	
2									01017
	Yolanda Humphr					eet Balt	OCATION — CI		
	1 🕏 Buriet 2 🗌 Cremetion 3 🗎 Rem	ovat from Stata C6	b. PLACE AND DATE (metery, crematory or o	ther place)					
	4 Donatton 5 Other (Specify)		rbutus			4/95 A	butu	s M	D.
	1/21-2/ N.Monroe St								
	NOUtha L	HECUN (CFSP #28	SH E.L.	Phillir	s F/H	Balto	., M	ID. 21217
	23. PART I. Enter the diseases, or check on board follows	complications that cause List only one cause on	d the deeth. Do r				dratory street	st,	Approximsta
						4 .	2		Onset and Death
	disease or condition resulting in death)	s. Atheros	sclem	tic Co	ronar	y Hrtery	1013	805	Years
	,	DUE TO (OR AS	A CONSEQUENCE OF	F):		/			
Z	Sequentielly list conditions,	b							
ERTIFICATION	If sny, lesding to immediate	DUE TO (OR AS	A CONSEGUENCE OF	F):					
2	CAUSE (Disease or Injury	с.							
분	that initiated events resulting in death) LAST	DUE TO (OR AS	A CONSEGUENCE OF	F):					
	leading in death, CAST	d							
0	PART II. Other significant condition	e contributing to deeth	but not resulting	in the underlyin	g ceuse given in	Part I. 24s. WAS A	NAUTOPSY	24b. W	VERE AUTOPSY FINDINGS
8						PERFO	RMED?	A	WAILABLE PRIOR TO COMPLETION OF CAUSE
MEDICA	-					1 _ YES	2 M NO	0	OF DEATH?
	DID TODA CCO LICE CONT	DIDLITE TO CALICE	DE DE ATIL VE	C D NO F	T UNICEDTAI	- I		1	YES 2 NO
AN	DID TOBACCO USE CONT	KIBUIE IO CAUSE	26. PLACE OF DEA	S NO [иЦ			
SICIAN:	EXAMINER?	HOSPITAL:		OTHER:	1				
l≺S	1 YES 2 W NO	1 Inpatient 2 ER/Ou 28a. DATE OF INJURY			na 5 M Residence			1000	
РНУ	1 Natural 5 Pending	(Month, Day, Year)		URY	JURY AT ORK?	28d. DESCRIBE HOW	INJURY OCCU	IRED	
ВУ	2 Accident Investigation	20- 01 405 05 10 10	M 415	M 1					
0	3 Suicide 6 Could not be 4 Homicide determined	28s. PLACE OF INJUF building, atc. (Sp	ecify)	street, ractory, orne	DIM:	28t. LOCATION (Street City or Town, Stett		r Hural Hou	ite Number,
P.	cool -	ICIAN: To the best of my kno							
COMPLET	2 MEDICAL EXAMINE	ER: On the beels of exeminati	on end/or investigation	n, in my opinion,	death occured at the	time, data end plece, e	nd due to the	cause(e) s	ind manner ee stated.
ш	296. SIGNATURE AND TITLE OF CERTIFIE	PO OF L	- 113		29c. LICENSE NUI	MBER	29d. DATE	SIGNED (A	Month, Day, Year)
0 8	Bennita 9	. Carte	NID		IP 19	728	1 /2	//3	195
2	30. NAME AND ADDRESS OF PERSON WH	O COMPLETED CAUSE OF D	EATH (ITEM 27) (Type	Print)	10 1	1.1	./ /	40	
	Kennita K. (arter U	niversi	ty of	Maryla	nd Hosp	ortal	dd	S. Greene St.
	31. DATE FILED (Month, Day Year)	32. REGISTRAR'S DIG	NATURE	1		1			
	1 UEU 1 0 1333 .9%	and the same of the							

ř. • 9 M Figure 1 and William 1

3. TIME OF DEATH

8. BIRTHPLACE (State or Foreign

9c. COUNTY OF DEATH

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BE

2

2 Accident

4 Homicide

29b. SIGNATURE AND TITLE OF CERTIFIES

6 Could not be

Sharon Mhuth-Morrow

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

Al'huth-Morrow M.D

3 Sulcide

this c is marked,

TO THE HOSPITAL
TO THE FUNERAL OF FILE WITHIN 72 h
IMPORTANT: If II

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DIVISION OF VITAL RECORDS, P.O. BOX 68760	E	E #
2	R	ES IN
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	F	马至
	THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hospitath. Page 6 ma	THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, p filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.
	-	- =

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF OEATH Dec 10, DAY 1995 YEAR Allan **Haley** Basham 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH IF UNDER 1 YEAR IF UNDER 24 HRS. Jan 15, 1988 219-21-6034 DAYS 1 X M 2 - F 07 YRS. 9a. FACILITY NAME (If not institution, give street and number, 9b. CITY, TOWN OR LOCATION OF DEATH 1001 Woodbourne Avenue DIRECTOR Baltimore RESIDENCE OF DECEDENT 10a. STATE 10b. COUNT 10c. CITY TOWN OR LOCATION N/A Md. **Baltimore** 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE 1001 Woodbourne Avenue 21212 12. WAS DECEDENT EYER IN U.S. ARMEO FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-1 K Never Married 2 Married Il yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 TYES 2 NO Specify BY 3 Widowed 4 Divorced 16e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16b. KIND OF BUSINESS/INDUSTRY (Give kind of work done during life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) Student 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Lowell Basham Ann Elizabeth Donohue BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5 Hattie Wood 1001 Woodbourne Ave. Baltimore, Md 21212 20a. METHOD OF DISPOSITION
1 X Burlel 2 Cremetion 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE Western Star Cem 12/14/95 Catonsville, Md. 4 Dopatton 5 Other (Specify) 22. NAME AND ADDRESS OF FACILITY Caple Funeral Service TUNERAL SERVICE LICENSEE 5502 Winner Ave. Baltimore 21215 23. PART i. Enter the diseases, of complications that caused the ds ahock, or heart failure. List only one cause on each line. complications that caused the dasth. Do not enter the mode of dying, such as cardiac or respiratory arrest, IMMEDIATE CAUSE (Final disease or condition . Complications of End Stage Lung Disease
Due to (OR AS A CONSEQUENCE OF): resulting in death) Pre umania.
DUE TO (OR AS A CONSEQUENCE OF): CERTIFICATION Sequentially list conditiona, If any, leading to immediate cause. Enter UNDERLYING Severe Demological Impairment CAUSE (Disease or Injury that initiated events reaulting in death) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. MEDICAL 24s. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) **EXAMINER?** OTHER: 1 YES 2 1 NO ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 → Residence 8 ☐ Other (Specify) 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 27. MANNER OF DEATH 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 SR Natural 5 Pending Investigation

28e. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify)

1 YES 2 NO

K 316/600 N. Wolfe St.

29c. LICENSE NUMBER

10d. INSIDE CITY X YES 2 NO 10g. CITIZEN OF WHAT COUNTRY? USA 14. RACE — American Indian, Black, White, etc. Specify: **Black** School 1 20c. LOCATION - City or Town, Stata Approximata Onset and Death 12 months month 7 years 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 29a. CERTIFIER
(Check only one)

2 MEDICAL EXAMINED: On the best of my knowledge, death occurred at the time, data and piace, and due to the cause(s) and manner as attacted. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and manner as stated. 29d. DATE SIGNED (Month, Day, Year)

OHMH-18 Rev 1/89

Bo Himory MD 21287-2537

	FOR STATE REGISTRAR		STATE OF I	MARYLA		EPART					MENT	AL HYGIEN					
	1. DECEDENT'S NAME (First	, Middle, Last)									2. DA	TE OF DEATH	MY		3. TIME OF DEATH		
1	FRANCIS CIESIELSKI							MOI	2.40 D M								
	4. SOCIAL SECURITY NUME		5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS.							7. DAT	Dec 13 1995 3:40 P						
	217-26-26	670	1X M 2 - F		65	YRS.	ONTHS	DAYS	HOURS	MIN.	Au	onth, Day, Year)	030	Count	yland		
	9e. FACILITY NAME (If not in	nstitution, give s	treet and number)				b. CITY,	TOWN 0	R LOCAT	ION OF D		9 14,		INTY OF DEATH			
۳ ا	7815 Mea	th Rd					Du	nda	1 k						more		
5	RESIDENCE OF DEC	CEDENT											1 200	1101	MOLC		
DIRECTOR	10e. STATE	10b. COUNTY			9	10c. CITY,	TOWN O	R LOCAT	ION						10d, INSIDE CITY LIMITS?		
- 1	Maryland		imore			Dι	and	a1k							1 TES 2 X NO		
₹	10e. STREET AND NUMBER								ZIP COD				10g. CIT	IZEN OF	WHAT COUNTRY?		
FUNERAL	7815 Mea	th Rd							212:	22				US	SA		
	11, MARITAL STATUS 1 Never Married 2 X		12. WAS DECEDER	T EVER IN	U.S. ARME	ED						GIN? (Specify Ye to Rican, atc.)	s or No-	14. RAC Blac	E — American Indian, ik, White, etc.		
BY	3 Widowed 4 Dive		IF YES, GIVE Y	MAR OR DA	TES					Speci		, , , , , , , , , , , , , , , , , , , ,		Spec	White		
		CEDENT'S EDUC	195	8 -	1959	DENT'S U		OLIDA TIC							WILLOE		
	(Specify on	ly highest grade	completed)		(Give	kind of wo	rk done o	luring mo	in at of world	ing		16b. KIND OF BU	JSINESS/IN	DUSTRY			
ן ב	Elementary/Secondary (I	0-12)	College (1-4 or 5	+)		ne E	,	zer				Stair	1000	- C+	001		
COMPLET	17. FATHER'S NAME (First, A	Aiddle, Last)			CIU	110 1	1001	7.6.1	18 MOT	NEB'S N	AME (Fig.	st, Middle, Maide		5 50	eer		
	Andrew C		1ski							kno		n, whole, was	r ournerne)				
BE	19e. INFORMANT'S NAME (19b. 1	MAILING A	DDRESS	(Street a				umber, City or To	wn. State. Zi	n Code)			
2	Dolores	Ciesi	elski		100	815						imore,			22		
1	20e. METNOD QF_DISPOSIT	TION		20b.	PLACEAN					100			OCATION -				
	1 Donation 5 Other		oval from State	Me Cem	etery, creme	Cre	er place)	tor	U		12.	-16 Ca	tons	svi 1	le. Md		
4 Donation 5 Other (Specify) Metro Crematory 112-16 Catonsville, 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Connelly Funeral Home of Dun 7110 Sollers Point RD. 21222																	
\dashv	23. PART i. Enter the d	inhanes, or	complications the	of counsel	the dela	Do no									Approximate		
ŀ	shock, or fi	reart failure.	List only one ca	use on se	ach line.	1		,,,,	ao o, a,	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	077 444 0	a. 0. a. 0. 10a	on atory ar	1001,	Interval Between		
	immediate cause (Fi	nei	1000	. 6	010	1.	nan	han	201						Onset and Death		
	resulting in death)		DUE/TI	ON AS A	CONSEQU	ENCE OF	TH	1101	//\						ve die		
-			BI	2012	m	dta	STA	10	8						13 800		
RTIFICATION	Sequentially list condition if any, leading to imme		DUE TO	-147	CONSEQU	JENCE OF)	V								1 - 1103		
3	cause. Enter UNDERLY CAUSE (Disease or inju	ING	С.														
	that initieted evente		DUE TO	(DR AS A	CONSEOU	JENCE DF):											
CER	reaulting in death) LAS	51 L	d														
	PART II. Other significa	ent condition	ns contributing to	deeth b	ut not res	suiting in	the un	derivin	ceuse	given ir	Part I	24s, WAS A	N AUTOPSY	24	b. WERE AUTOPSY FINDINGS		
SA												PERFO	PRMED?		AWAILABLE PRIOR TO COMPLETION OF CAUSE		
EDIC						_					-	1 TYES	2 NO		OF DEATN?		
Σ	DID TOBACCO U	ISE CONT	RIBLITE TO CA	ALISE O	E DEAT	H YES		VO X	LIN	CERTA	IN \Box				1 YES 2 NO		
HYSICIAN:	25. WAS CASE REFERRED				26. PLACE				1011	CLICITA							
	EXAMINER?		HOSPITAL: 1 Inputient 2	☐ ER/Outp	etient 3		OTHER I Num		· oti	Residence	6 0	ther (Specify)					
Ħ	27. MANNER OF DEATN		28m. DATE O	F INJURY		28b. TIME	OF	28c. INJ	URY AT		T	DESCRIBE NOW	INJURY OC	CURED			
<u>-</u>		Pending Investigation	(Month,	Day, Year)		INJU	M	1 🔲	PK?	□ NO							
D BY	2 Accident 3 Suicide 8	Could not be	26e. PLACE	OF INJURY	— At home	e, ferm, atı	reat, fact	ory, offic			281. L	OCATION (Stree	end Numbe	or Rural	Route Number,		
Ш	4 Nomicide	detarmined	building	, en. (opec	arf)						1 '	Any or lown, Stet	7				
MPLET	29m. CERTIFIER (Check only	TIFYING PNYS	ICIAN: To the best of	f my knowi	ledge, dest	h occurred	at the ti	me, date	and plec	e, end du	e 10 1he	cause(s) and m	onner se ste	rted.			
M															(s) end menner es stated.		
8	295. SIGNATURE AND THE		/	-	-	-				CENSE NU			-		Q/(Month, Dey, Year)		
B	Malin	11/1	m	1	-//				7	335	15	1)	12/	14/65		
2	30. NAME AND ADDRESS O	PERSON WH	O COMPLETED CA	JSE OF DIL	атн (гтем	27) (Type, F	Print)		1/			/		1	11-12		
F	Michael A	norba	al M D	0	000	Dece	. 1 . 1				-	-		/	/ 0005		

31. DATE FILED (Mornth, Day, Year)
DEC 1 5 1995

32. REGISTRAR'S SIGNATURE

D. 91

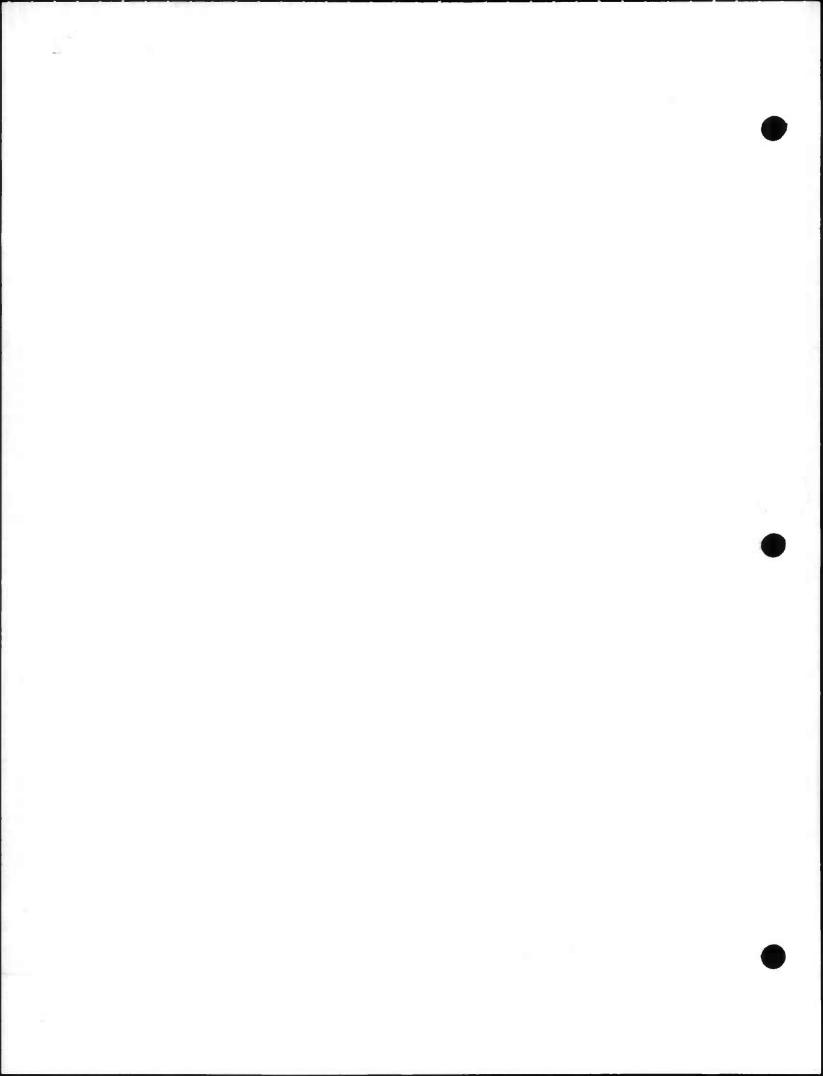
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LOR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after	. DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the home	crematic
cuted	d con	urial.
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DIVISION OF VITAL RECORDS, P.O. BOX 68760,

	FOR 1 - STATE REGISTRAR	STATE OF MARYL		MENT OF I		MENTA	AL HYGIEN				
19	1. DECEDENT'S NAME (First, Middle, Last)	1	\wedge			E OF DEATH	OF DEATH 3. TIME OF DEATH				
	Vernon I	Janiel	(),	DSS		MON	PULDES		YEAR	715	AM
	4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE	OF BIRTH	T	BIRTHE	LACE (State or F	oreign				
Į.	216-01-6050		30 yrs.	MONTHS DAYS	HOURS MIN,	JAN	^{th, 275} , 1	.915 M	15 Maryland		
œ	96. FACILITY NAME (If not institution, give :				OR LOCATION OF D			9c. COUNT		ATH	
DIRECTOR	Bon Secours Exte	nueu care		FITIC	ott City			Howa	ard		
EC	10e. STATE 10b. COUNT	Υ	10c. CITY	TOWN OR LOCA	TION				T	10d. INSIDE CIT	Υ
	Maryland Howa	rd			Elkrid	ge				LIMITS?	NO NO
FUNERAL	10e. STREET AND NUMBER	Dood Amb 2	C	10	. ZIP CODE	. 7				HAT COUNTRY?	
NE	7242 Montgomery				2122				USA		
	1 Never Married 2 Married	12. WAS DECEDENT EVER I FORCES? 1 . YES	N U.S. ARMED 2 NO	If yes, or	CENDENT OF HISPA ecity Cubers, Mexico	en, Puerto	IN? (Specify Ye Rican, etc.)	s or No— 1		- American Ind White, etc.	lien,
B	3 Widowed 4 Divorced	IF YES, GIVE WAR OR D		1 TYES	2 XNO Speci	ly:		A. 17	Specify	White	
COMPLETED	15. DECEDENT'S EDU (Specify only highest grade	ICATION e completed)	16a. DECEDENT'S I	JSUAL OCCUPATI	ON of working	16	b. KIND OF BU	SINESS/INDU	STRY		
	Elementary/Secondary (0-12)	College (1-4 or 5+)	life. Do NOT use	retired.)	of by working						
MP	8		Laborer			_	Shippi		ece:	iving	
	17. FATHER'S NAME (First, Middle, Last) HOWard Man	shall Cross			18. MOTHER'S NA		Middle Meiden		-		
H	19a. INFORMANT'S NAME (Type/Print)	SHALL CLOSS	19h MAII ING	ADDRESS (Street	and Number or Rural						
2	Ramona P. Cross				y Rd.,					MD 2122	7
	20a. METHOD OF DISPOSITION		PLACE AND DATE O	F DISPOSITION (N	ame of	DA	TE 20c. LC	CATION - CH	ty or Tow	m, State	
	1 Donation 5 Other (Specify)	Me Me	tro Crem	atory,	Inc. 12/	13/9	5 Ba	altimo	re,	MD	
Ä	21. SIGNATURE OF FUNERAL SERVICE LA	Dawn F. M	/cDonald	22. NAME A	NO ADDRESS OF FA	CUTY	of Ma	ryl and	I Tı	nc	
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE Dawn F. McDonald Cremation Society of Maryland, Inc. 299 Frederick Rd. Baltimore, MD 21228										
	23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. Approximate interval Between										
	IMMEDIATE CAUSE (Final	C C C C C C C C C C C C C C C C C C C	won into.	-						Onset an	d Death
	disease or condition resulting in death)		eatic		cer					13 Mor	Ths
	111111111111111111111111111111111111111	DUE TO (OR AS	CONSEQUENCE OF):							
ON	Sequentially list conditions,	b DUE TO (OR AS /	CONSEQUENCE OF							-	
¥	if any, leading to immediate cause. Enter UNDERLYING									İ	
Ĭ	CAUSE (Disease or Injury that initiated events	DUE TO (OR AS /	CONSEQUENCE OF	:						1	
CERTIFICATION	resulting in death) LAST	d									
AL C	PART II. Other aignificant condition	ns contributing to death t	out not resulting in	the underlyin	g ceuse given in	Part I.	24e, WAS AN	AUTOPSY	24b.	WERE AUTOPSY I	FINDINGS
S							PERFO		1 1	MAILABLE PRIOR COMPLETION OF	
AED A								Mino		OF DEATH?	NO.
ä										× 110 × 1	
PHYSICIAN: MEDIC	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL;			ACE OF DEATH (C)	eck only a	ine)		1		
YSI	1 TES 2 THO	1 Inpetient 2 ER/Out	petient 3 DOA	OTHER: Nursing Hon	e 5 🗆 Residence	8 🗆 Oth	er (Specify)				
	27, MANNER OF DEATH 1 Natural 5 Pending	26a. DATE OF INJURY (Month, Day, Year)	28b. TIME INJL	IRY WO	PRK?	28d. DE	SCRIBE HOW	NJURY OCCU	RED		
B	2 Accident Investigation	26s. PLACE OF INJURY	. At here to		YES 2 NO						
COMPLETED	3 Suicide 6 Could not be 4 Homicide determined	building, etc. (Spe	cify)	reet, tactory, offic	•	C/h	CATION (Street or Town, State)	and Number or	- Hurat Ro	ute Number,	
9	29a. CERTIFIER	(Class To the boat of the last									
MP		ICIAN: To the best of my know ER: On the basis of examination								and manner as	
	29b. SIGNATURE AND TITLE OF CERTIFIE			,, op.iioii, i	100000		e ano piece, er				
BE	Steve Sell.	- MO			D 346	13		P MA	SIGNED (Month, Day, Year,	6
유	30. NAME AND ADDRESS OF PERSON WH		ATH (ITEM 27) (Type,	Print)	0210	1)		U.E		2114	10
	Steven Gelle	- MO 950	010	mapolis	Rd E	Illico	H Cin	MO	2	1042	
	DEC 1 5 1995	32. REGISTRAR'S SIGN		1			1	V			
- 1	DEO T 0 1999	/									





FOR STATE REGISTRAR

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VISION OF VI	TTENDING PHYSICIAN
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	2

	1. DECEDENT'S NAME (FIRST, MIGGIE, Las	Frances Eve	lyn E	Bryan Cro	ck		Dec.	11,	1995	YEAR 3.	8:45 PM	M
	4. SOCIAL SECURITY NUMBER		SE (In yrs. Ia	MONTHS	DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF (Month, C	BIRTH Day, Year)		Country)	ACE (State or Foreign	
	218-01-3684 9a. FACILITY NAME (If not institution, giv	1 M 2 F	88	YRS.	Y TOWAL	OR LOCATION OF D	July	12,	1907]			_
۳.	Keswick Home	700 W. 40th	Stree		alti		LAIN				e City	
CTOR	RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY											
DIRE	Maryland Baltimore City			10c. CITY, TOWN	timore				LIMITS? YES 2 NO			
FUNERAL	100. STREET AND NUMBER Keswick Home	Stre	et	E ZIP CODE	1211		US US	AT COUNTRY?				
B	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVE FORCES? 1 1 YE IF YES, GIVE WAR OF	ES 2XX		if yes, sp		can, Puarto Rican, etc.) Blac				American Indian, White, etc. White	
ETEO	15. DECEDENT'S EDUCATION (Specify only highest grade completed)			ECEDENT'S USUAL Give kind of work don e. Do NOT use retired		16b. KIND OF BUSINESS/INDUSTRY					-	
OMPLE	Elementary/Secondary (0-12) 12	College (1-4 or 5 +) 4		Homema								
ပ၂	17. FATHER'S NAME (First, Middle, Lest) Lyman Bryan					18. MOTHER'S NAME (First, Middle, Malden Surname)						
B	19a. INFORMANT'S NAME (Type/Print)	Dynair Dry		Carrie Lee Tynes 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)								_
임	Thomas R. Crock					ew Court		,			312	
	20e. METHOD OF DISPOSITION 1 10 Burlet 2 Cremetion 3 R			AND DATE OF DISP		ame of	DATE 20c. LOCATION — City or Town, State					
,				Claire's	Cem		12/14	Gre	ensbur	q, F	PA	
	· Scacey Hers Corpenter			E	urge	AND ADDRESS OF FACILITY DEC-HENSS Funeral Home Falls Road Baltimore, MD 21211						
CERTIFICATION	shock, or heeft failure. List only one cause on each line. IMMEDIATE CAUSE (Finel disease or condition resulting in deeth) Sequentially list conditions, if any, leading to immediate cause. Entar UNDERLYING CAUSE (Disease or injury that initiated events resulting in deeth) LAST List only one cause on each line. Interval Batweer Onset and Daeth DUE TO (OR AS A CONSEQUENCE OF):										2	
MEDICAL	PERFORMED? 1 YES 2 NO									C	YERE AUTOPSY FINDINGS WAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? YES 2 NO	20
	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one)											
PHYSICIAN	28. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 PLACE OF DEATH (Check only one) 1 YES 2 PLACE OF DEATH (Check only one) 1 YES 2 PLACE OF DEATH (Check only one) 1 YES 2 PLACE OF DEATH (Check only one) 1 YES 2 PLACE OF DEATH (Check only one)											
/ PHY	27. MANNER OF DEATH t W Natural 5 Pending	28a. DATE OF INJUI (Month, Day, Yea	28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY				NJURY AT 28d. DESCRIBE HOW INJURY OCCU			RED		
TED B	2 Accident investigation 3 Suicide 8 Could not be detarmined 28e. PLACE OF INJURY — At home, ferm, strest, factory, office building, stc. (Specify)						Hice 281. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
COMPLET	nee!		28e. PLACE OF INJURY — At home, ferm, street, factory, office building, atc. (Specify) W: To the best of my knowledge, death occurred at the time, date and place, on the best of examination and/or investigation, in my opinion, death occurred.									
TO BE	296 SIGNATURE AND TITLE OF CERTI	2		29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Da 29d. DATE SIGNED (Month), Da 30d. DATE SIGNED (Month), DATE SIGNED (Month), DATE SIGNED (Month), DATE SIGNED (Month), DATE SIGNED (Month), DATE SIGNED (Month), DATE SIGNED (Month), DATE SIGNED (Month), DATE SIGNED (Month), DATE SIGNED (Month), DATE SIGNED (Month), DATE SIGNED (Month), DATE SIGNED (Month), DATE SIGNED (Month), DATE SIGNED (Month), DATE SIGNED (Month), DATE SIGNED (Month), DATE SIGNED (Month), DATE SIGNED (MONTH), DATE SIGNED (MONTH), DATE SIGNED (MONTH), DATE SIGNED (MONTH), DATE SIGNED (MONTH), DATE SIGNED (MONTH), DATE SIGNED (MONT					(onth, Day, Year) 3	ween		
	30. NAME AND ADDRESS OF PERSON E. Hunter Wilso				t Ba	altimore,	Mary	land	2120	4		woenly k
	31. DATE FILED (Month, Day, Year) DEC 1 5 1995	32. REGISTRAR'S S										

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.



DHMH-16 Rev 1/89

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Ì	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours with the death certificate by the hospital or	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for us	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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	FOR 1 - STATE REGISTRAR	STATE OF I	MARYLAND /	DEPAR						REG. NO			
	1. DECEDENT'S NAME (First, Middle, Last) RICKY	L DICKENS							2. DATE OF DEATH MONTH DAY PEAR PEAR				3. TIME OF DEATH 4:17 pm M
	4. SOCIAL SECURITY NUMBER 220–68–0832	5. SEX 6. AGE (In yrs. last 38		et birthday) YRS.	MONTHS DAVE		HOURS	MIN.	7. DATE OF BIRTH (Month, Day, Year) APR 24, 1		8. BIRTHPLACE (State		HPLACE (State or Foreign ory)
TOR	99. FACILITY NAME (If not institution, give st Saint Joseph Medic RESIDENCE OF DECEDENT		9b. CITY, TOWN OR LOCATION OF DEATH TOWSON, Maryland Sc. COUNTY OF DE Baltimon							DEATH			
DIREC	Maryland N/A		10c. CITY, TOWN OR LOCATION Baltimo					ore				10d. INSIDE CITY LIMITS? 1X YES 2 NO	
FUNERAL DIRECTOR	4804 Hamilton Ave		101. ZIP CODE 10g. CITIZEN OF WHA 21206 USA							WHAT COUNTRY?			
B	11. MARITAL STATUS LA Never Married 2 Married 3 Widowed 4 Divorced	RMED NO	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 YES 2 NO Specify: Specify						E — American Indian, k, Whita, etc. Black				
COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5 +) 5 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Bank Examiner Specialist State of Maryland										nd		
	17. FATHER'S NAME (First, Middle, Last)		18. MOTHER'S NAME (First, Middle, Malden Surname)										
BE	Jesse Cochr 19a. INFORMANT'S NAME (Typo/Print)	b. MAILING	Jenita Mae Elmore A ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)										
2	Jenita Mae Dicken	ns											MD 21206
	Jenita Mae Dickens 4804 Hamilton Ave., Apt. D3 Baltimore, MD 2120 20e. METHOD OF DISPOSITION 1 Burlel 2 N Cremation 3 Removel from State 4 Donestion 5 Other (Specify) DATE 20e. LOCATION - City or Town, State Metro Crematory, Inc. 12/14/95 Baltimore, MD										mn, State		
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE Dawn F. McDonald 22. NAME AND ADDRESS OF FACILITY Cremation Society of Maryland, Inc. 299 Frederick Rd. Baltimore, MD 21											Inc. 21228	
	23. PART I. Enter the diseases, or compilections that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, ahock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) a. GRAM NEGATIVE SEPSIS											Approximate interval Between Onset and Death 2 DAYS	
z	DUE TO (OR AS A CONSEQUENCE OF): ACUTE RENAL FAILURE											2 DAYS	
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events reaulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):											4 YEARS	
PHYSICIAN: MEDICAL C	1 — YES 3 NO ON									WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO			
CIA	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATH (Check only one) OTHER:												
red BY	Accident Investigation Guide Gould not be determined	me, farm, r	M 1 YES 2 NO				281. LOCATION (Street and Number or Rural Route Number, City or Town, State)						
COMPLETED	29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated. 2 MEDIAND EXAMINER: On the best of axamination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and manner as stated.												
TO BE C	296. SIGNATURE AND TIME OF CENTRIER		29c. LICENSE NUI D3681 4							1			
	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CADE OF DEATH (ITEM 27) (Type, Print) RICHARD L. HUSLIG M.D. 3605 OSLER DR. SUITE 504 TOWSON, MD. 21204											1	
	31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE 32. REGISTRAR'S SIGNATURE												

	TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2% now after with Plan in may be retained by the host	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and comparing little to by the attending by desiran		IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumaits event, the medical examiner must be notified at once.	
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	1 - STATE REGISTRAR	STATE OF MARYL	AND / DEPAH CERTIF	ICATE C	F HEALIH	AND N	MENTAL HYGIE REG. NO				
	1. DECEDENT'S NAME (First, Middle, Lest)	Dun	ba	R			2. DATE OF DEATH MONTH December	\$\rangle +4	YEAR 3.	3:25 PM	
-		5. SEX 8. AGE	(In yrs. last birthday) 9 YRS.	IF UNDER 1 YE		24 HRS. MIN.	7. DATE OF BIRTH (Month, Day, Year)	_	Country)	ACE (State or Foreign	
	9a, FACILITY NAME (If not inatitution, give stree		J Tha.	9b. CITY. TO	WN OR LOCATION	ON OF DE	04-20-1		S. Ca.	rolina	
5	Deaton Specialt		1	В	altim	ore			N/A		
5	RESIDENCE OF DECEDENT 10a, STATE 10b, COUNTY			Y, TOWN OR LO	OCATION				10	d, INSIDE CITY	
DIMECTOR	MD. N/A				altim	ore			15	LIMITS?	
FUNEHAL	10e. STREET AND NUMBER 718 N. Appleton	Street			101. ZIP CODI 2121			10g. Cl	10g. CITIZEN OF WHAT COUNTRY?		
0		IN U.S. ARMED 2 NO DATES 145	13. WAS	Black, V	American Indian, Vhite, atc. Black						
ED	t5. DECEDENT'S EDUCA (Specify only highest grade co	TION ompleted)	16a. DECEDENT'S (Give kind of	work done durin	PATION g most of working	19	16b. KIND OF 8	USINESS/IN	IDUSTRY		
COMPLE	Elementary/Secondary (0-12)	College (1-4 or 5+)	Longsh		ın		Steam	nshij	o Tra	de Assoc.	
2	17. FATHER'S NAME (First, Middle, Last)				18. MOT		ME (First, Middle, Meide				
מב	Unknown						Washing		=====		
0	190. INFORMANT'S NAME (Type/Print) Lou Ellen Dunb	or					t. Balto			1217	
	2ge. METHOD OF DISPOSITION 10 Burial 2 Cremation 3 Remov	20	b. PLACE AND DATE	OF DISPOSITIO	N (Name of		DATE 20c. I	OCATION -	- City or Town	, State	
	4 Donation 5 Other (Specify)	6	arrisor				2/15 0	ving	smill	s, MD.	
	21. SIGNATURE OF FUNERAL SERVICE LICE	1	SP #281		IE AND ADDRE		s F/H R	21-2	7 N.M	onroe St.	
CERTIFICATION	23. PART I. Enter the diseases, or co shock, or heart failure. Li IMMEDIATE CAUSE (Finel disease or condition resulting in death) Sequentially list conditions, if any, leading to immediata ceuse. Enter UNDERLYING CAUSE (Disease or Injury that intilietad eventa resulting in death) LAST	DUE TO (OR AS	aach line.	ZENA			SUFFICE			Approximate Intervel Between Onset and Death 3 Y .	
N: MEDICAL	DID TOBACCO USE CONTRI 25. WAS CASE REFERRED TO MEDICAL	POSITIVE BUTE TO CAUSE O	SNTIA F PPD	ES NO	ET ES	given in	PERF	AN AUTOPS' DRMED?	C	TERE AUTOPSY FINDINGS MAILABLE PRIOR TO OMPLETION DF CAUSE F DEATH? YES 2 NO	
SICIA		HOSPITAL: 1 Inpatient 2 ER/Out	tpetient 3 DOA	OTHER:	Home 5 🗆 R	esidence	8 Other (Specify)				
PHY	27. MANNER OF DEATH 1 X Netural 5 Pending	28a. DATE OF INJURY (Month, Day, Year)	28b. TII	JURY	WORK?	¬ NO	28d. DESCRIBE HOV	INJURY O	CCURED		
ED BY	2 Accident investigation 3 Suicide 8 Could not be 4 Homicide datarmined	28e. PLACE OF INJUR building, atc. (Sp.	RY — At home, ferm, ecify)				28f. LOCATION (Stre City or Town, Sta		per or Rural Roo	ste Number,	
COMPLET	(Check only	IAN: To the best of my kno								and manner as stated.	
O BE C	29b. SIGNATURE AND TITLE OF CERNIFIER 30, NAME AND ADDRESS OF PERSON WHO	Whlla	Que	a Orient)	29c. LIC	CENSE NU	MBER 6	29d, Di	ATE SIGNED (A	Aonth, Day, Year) 8, 1995	
	BRIAN C. W	JALLACE	5 MD	611	5. (CHA	RIES S	F /	BACTH	was mo	
	DEC 1 5 1995	A STANDARD	A COLOR								

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DIVISION OF VITAL RECORDS, P.O. BOX 68760

G PHYS	NS Ce	
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the d	S	MPORTANT: If Item 28 is marked, or Item 23 shows any Injur

										90	30	000
	1 - FOR STATE REGISTRAR	STATE OF MAR	RYLAND /	DEPAR	TMENT	OF HE	EALTH DEAT	AND I	MENTAL HYGIEN			
	1. DECEDENT'S NAME (First, Middle, Last)								2. DATE OF DEATN			. TIME OF DEATN
	Raymond Herman I	Diegert							December	7. 19	YEAR	9:15 a M
	4. SOCIAL SECURITY NUMBER	5. SEX 6.	AGE (In yrs. lest	birthday)	IF UNDER 1	YEAR	IF UNDER	24 HRS.	7. DATE OF BIRTH		B. BIRTHPL	ACE (State or Foreign
	213-18-7337	1 🛛 M 2 🗆 F	76	YRS.	MONTHS	DAYS	HOURS	MIN.	(Month, Day, Year)		Country	Lmore Co.Md.
	9s. FACILITY NAME (If not institution, give st	reet and number)	70		9b. CITY, 1	DWN OF	RLOCATIO	ON OF DE			TY OF DEA	
Œ	Bel Forest Nursing	Cente	r			rest				larfo		
5	RESIDENCE OF DECEDENT	J a Kellab.	Cente	1		1 01	636	1111	1	П	a110	ı u
DIRECTOR	10a. STATE 10b. COUNTY			10c. CIT	Y, TOWN OR	LOCATIO	ON				1	Od. INSIDE CITY
ā	Maryland Balti	Lmore		{	Baltir	nore)				1	LIMITS?
AL	10e. STREET AND NUMBER					10f.	ZIP CODE			10g. CITIZ		AT COUNTRY?
E	8017 Belair Road						212	236			U.S.A	1
11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yee or No— 14. RACE — American In Black, White, stc.												
BY	3 Widowed 4 Divorced	Apr.1942-N	March 8	3 <u>,</u> 194	6		44	,			Spec/ly: Whit	е
逆	15. DECEDENT'S EDUC (Specify only highest grade	ATION completed)	16a. DEC	CEDENT'S	USUAL OCC	UPATION	N t of working	a	16b, KIND OF BUS	SINESS/INDL	STRY	
Ш	Elementary/Secondary (0-12)	College (1-4 or 5 +)	life.	Do NOT us	retired.)					_		
¥	8th.		Sp	ray	Paint	er			AeroSpa	ce Ir	idust	ry
COMPLETED	17. FATHER'S NAME (First, Middle, Last)								ME (First, Middle, Maiden	Surname)		
8	August Diegert								remper			
70	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)											
	F.O. Box / Paliston, Maryland 2104/											
	20e. METNOD OF DISPOSITION 1 X Buriel 2 Cremation 3 Remo	val from State	20b. PLACE A	ND DATE	OF DISPOSIT	ION (Nam	ne of		DATE 20c. LO	CATION — C	ity or Town	i, State
	4 Donation 6 Other (Specify)	211-4-7-3-11-2	St. Jose	oh's	Church	Ceme	etery	12/9	9/1995 Balt	timore	∍,Mar	yland
	21. SIGNATURE OF FUNERAL SERVICE LIC		/	V			ADDRES		owy Funeral H	lomo		
	6.7,	Jassa	hr	,					Road King		0 M	d 21087
	23. PART I. Enter the disease, or c	omplications that ca	used the dec	eth. Do r	ot enter th	ne mod	e of dyle	ng, eucl	h ee cerdlec or respi	ratory erre	et.	Approximete
	ahock, or heart fellure. I	lat only one ceuee o	on each line.				•			,		Interval Between Onset end Deeth
	disease or condition	/ 1	2 . 0 . 0	Oh	· Nous	44-	, 0	uls.	0.4	A		Onset end Deeth
	resulting in death)	DUE TO (OR AS A CONSEQUENCE OF):										
-	disease or condition a. Charic charter pulmman Distance Due to (or as a consequence of): Sequentially list conditions Due to (or as a consequence of): Year											
₫	Sequentially list conditione, If any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF):											1 y ans
8	cause. Enter UNDERLYING											[
Ĭ.	CAUSE (Disease or Injury that initiated events	DUE TO (OR	AS A CONSEO	UENCE OI	7):							
CERTIFICATION	resulting in deeth) LAST	L										!
0	DART II Other elegitions and discus-											
MEDICAL	PART II. Other eignificent conditions	Contributing to dee	oth but not re	euiting	à.				Part I. 24a. WAS AN PERFOR			ERE AUTOPSY FINDINGS VAILABLE PRIOR TO
ă	- a roman	1 hours	amoid	1	2170	plh	rph i	G	1 YES 2	NO		OMPLETION OF CAUSE F DEATH?
×									_ '		1	☐ YES 2 ☐ NO
PHYSICIAN:	DID TOBACCO USE CONTR	IBUTE TO CAUS					UNC	ERTAIN	4 D			
S	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLACE	OF DEAT	H (Check on	ly one)						
YS	1 TYES 2 NO	1 Inpatient 2 ER		□ DOA	4 Nursin	g Home	5 🗆 Ree	eldence	6 Other (Specify)			
표	27. MANNER OF DEATH Natural 5 Pending	28a. DATE OF INJU	JRY bar)	26b. TIM	URY	Bc. INJUI	K?		28d. DESCRIBE HOW I	NJURY OCCU	JRED	
Β¥	2 Accident Investigation						S 2 _	NO				
E	3 Suicide 6 Could not be 4 Homicide determined	28e. PLACE OF IN. building, stc.	JURY — At hom (Specify)	ne, larm, s	treet, factor	y, office			261. LOCATION (Street a City or Town, State)	and Number o	r Rural Rou	te Number,
E												
PL	29a. CERTIFIER 1 CERTIFYING PHYSIC	CIAN: To the beat of my I	knowledge, dea	th occurre	d at the time	e, date a	nd placa,	and due	to the cause(e) and man	ner se state	d.	
COMPLET	one) 2 MEDICAL EXAMINER											nd manner se stated.
	29b. SIGNATURE AND TITLE OF CERTIFIER		1,				29c. LICEI					Ionth, Day, Year)
8		a 1	114				1	20	975	10	12/	0,0
2	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE O	F DEATN (ITEM	27) (Type,	Print)		17	~ (, ,		-///	7

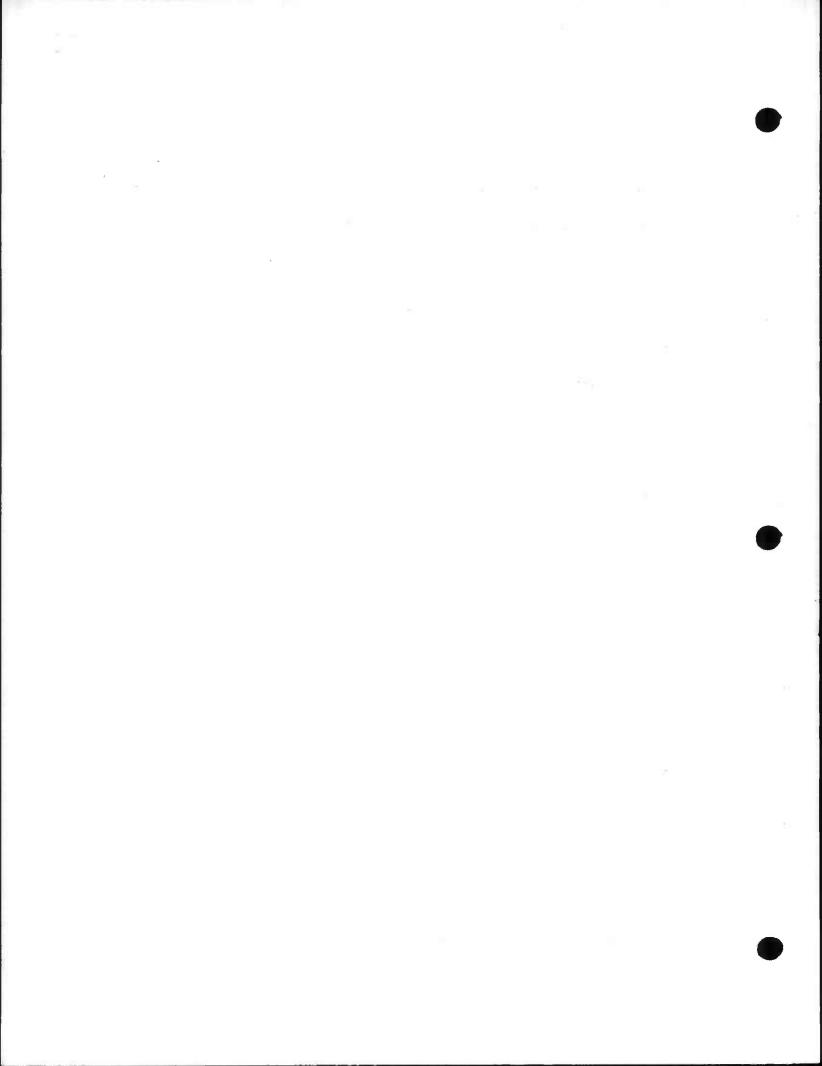
Olive and

32. REGISTRAR'S SIGNATURE

Animulan Randoll

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	W BALTIMORE, MARYLAND 21215-0020	ath. Page 6 may be retained by the hospital or attending physicis
	TIMORE,	th. Page 6 may b
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	TAL	The law
	F VITAL	SICIAN: The law
	ON OF VITAL	ING PHYSICIAN: The law
	DIVISION OF VITAL RECORDS, P.O. BOX 68761	OR ATTENDING PHYSICIAN. The law requires that the death certificate be ex

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 21 heart of the funeral director, page 5 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Merital Hygiene prior to bunial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

	STATE OF MARYLAND / DEPARTMENT OF HEALTH AND CERTIFICATE OF DEATH	MENTAL	HYGIENE REG. NO.
ist)		2. DATE O	F DEATH

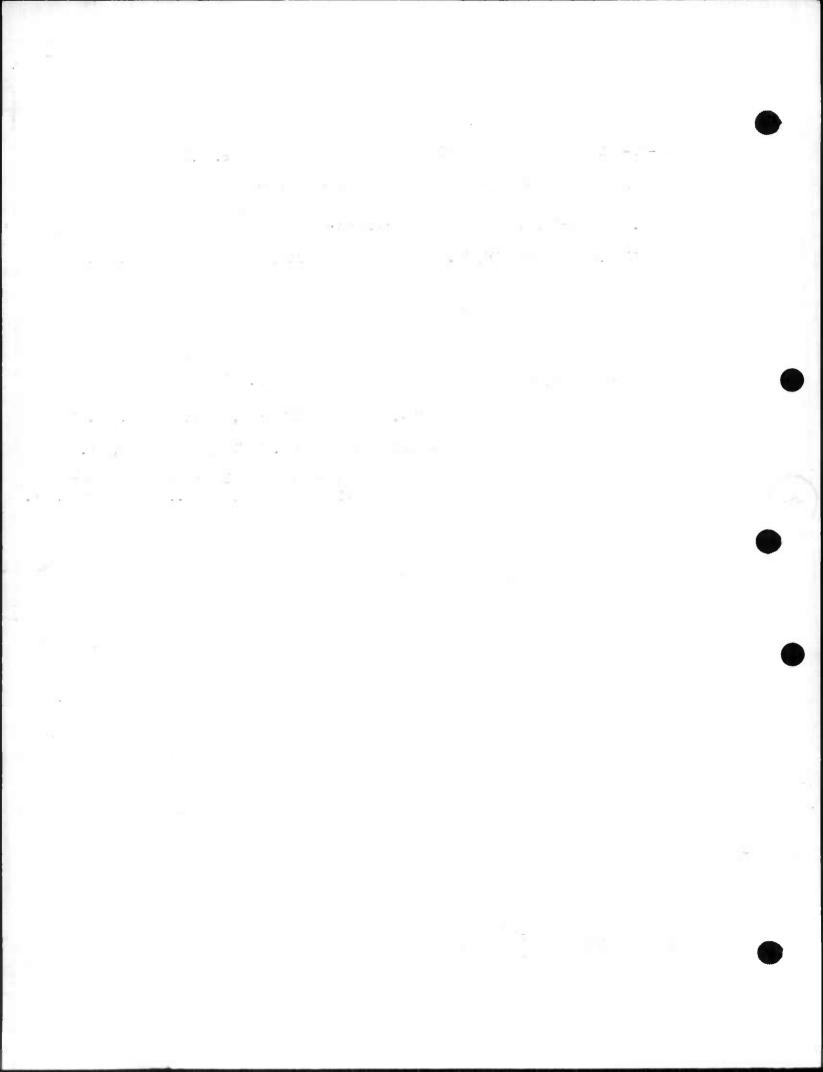
	FOR STATE REGISTRAR	STATE OF MARYL		MENT OF H		D ME	NTAL HYGIENE					
	1. DECEDENT'S NAME (First, Middle, Last)						DATE OF DEATH			. TIME OF OEATH		
	RICHARD ARLAND	DARNELL SE	-			I		199		6:15A.M		
	216-36-3075	1 XM 2 F		F UNDER 1 YEAR	IF UNDER 24 HR	N. De	DATE OF BIRTH	39 W	LEST	ACE (State or Foreign Virginia		
	9a. FACILITY NAME (If not institution, give st	reet and number)		9b. CITY, TOWN	R LOCATION O	F DEATH	1	9c. COUNT	Y OF DEA	тн		
OR	Stella MAris	Hospice		T	owson			E	Balt	imore		
2	RESIDENCE OF DECEDENT 10a, STATE 10b, COUNTY		10c CITY	TOWN OR LOCA		Dd. INSIDE CITY						
DIRECTOR	Md. H	Baltimore				Dur	ndalk	LIMITS?				
FUNERAL	10e. STREET AND NUMBER			10		AT COUNTRY?						
Ä	3112 Yorkway						222		USA			
	11. MARITAL STATUS 1 Never Merried 2 Married	12. WAS DECEDENT EVER IN FORCES? 13 YES	2 NO	If yes, sp	city Cuban, Me	xican, P	ORIGIN? (Specify Yea uerto Rican, etc.)	or No-	Black, 1	- Americen Indian, White, etc.		
ВУ	3 Widowed 4 Divorced	IF YES, GIVE WAR OR DA	ALES.	I I TES	2 NO S	овсіўу:			Specify:	White		
	15, DECEDENT'S EDUC (Specify only highest grade	CATION completed)	18a. DECEDENT'S U	ork done during mo			16b. KIND OF BUS	INESS/INDUS	STRY			
COMPLETED	Elementary/Secondary (0-12)	College (1-4 or 5 +)	life. Do NOT use				Poti	n Ste	0.1	100		
OM	17. FATHER'S NAME (First, Middle, Last)	2yrs	Compi	rters	18. MOTHER'S	S NAME ((First, Middle, Meiden S		:61			
BE C	Raymond T.	Darnell			100		l Willia					
TO B	19a. INFORMANT'S NAME (Type/Print)		19b. MAILING	ADDRESS (Street)			Number, City or Town		ode)			
-	Raymond Darne					oad	Baltimo					
	20a. METHOD OF DISPOSITION 1 Removal from Stata 4 Donatton 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of Camelory or other place) Camelory or other place of Faith 12/16/95 ROSSVIILE Md.											
	21. SIGNATURE OF FUNERAL SERVICE LIC		ardens c	-	ID ADDRESS OF			J88 V I	LILE	MO.		
	DR Tall	(0	11.		_		neral Ho					
	23. PART I. Enter the diseases, or c	donne that caused	the death/Down				e. Balti			21221		
	ahock, or heert fellure. I IMMEDIATE CAUSE (Finel	Ist only one ceuse on e	ech line.				a cordiac or reapi	atory arros		Interval Between Onset and Death		
	disease or condition resulting in death) • COLORECTAL CANCER									4urs.		
	DUE TO (OR AS A CONSEQUENCE OF):									9		
8	Sequentially list conditions, DUF TO (OR AS A CONSCOURAGE OF)											
CERTIFICATION	If any, leading to immediate cause. Enter UNDERLYING											
F	CAUSE (Disease or injury thet initiated events	DUE TO (OR AS A	CONSEQUENCE OF)	:								
E	resulting in death) LAST	J										
AL C	PART II. Other significent condition	s contributing to deeth b	ut not resulting in	the underlyin	cause giver	n In Par				ERE AUTOPSY FINDINGS		
20							PERFORI		0	MAILABLE PRIOR TO OMPLETION DF CAUSE OF DEATH?		
PHYSICIAN: MEDIC						_				YES 2 NO		
ä	DID TOBACCO USE CONTE				UNCERT	[AIN]	风					
5	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO	HOSPITAL:		OTHER:								
HYS	27. MANNER OF DEATH	1 Inpatient 2 ER/Outp	28b. TIME				Other (Specify) H(
ВУ Р	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	INJU	RY WO	RK? YES 2 NO							
	3 Suicide 8 Could not be	28e. PLACE OF INJURY building, atc. (Spec	- At home, ferm, at	reet, factory, offic	•	28	if, LOCATION (Street e. City or Town, State)	nd Number o	r Rural Rou	ite Number,		
ETE	4 Homicide determined											
COMPLET	and a	CIAN: To the best of my know										
8		R: On the beele of examination	n and/or investigation	, in my opinion, o	eath occured at	t the time	e, date and place, and	due to the	cause(a) a	and manner as stated.		
H	296. SIGNATURE AND TITLE OF CERTIFIER	Gano 4 110	1 4400		29c. LICENSE	NUMBE	4-2	29d. DATE :	SIGNED (A	forith, Day, Year)		
5	30. NAME AND ADDRESS OF PERSON WHO	O COMPLETED CAUSE OF DE	ATH (ITEM 27) (Type. I	Print)	1000	20.	10		13	742		
	DR. KENDALL FAUL				, 'TYOTA	TSONT	MD 212	04				
	31. DATE FILED MONTS 1995	L. BARGINIAR STEN	ALL.		, IOW		<u> </u>	V-1				
	DEG - 0 1000											

DEC 1 5 199

DIVISION OF VITAL RECORDS, P.O. BOX 68760

	1 - FOR STATE REGISTRAR		STATE OF !	MARYLAND /		RTMENT				MENTAI	HYGIEN			
	1. DECEDENT'S NAME (First		E D	EBLA						MONTH	OF DEATH	AY	YEAR 7	3. TIME OF DEATH
	4. SOCIAL SECURITY NUMBER 212-20-8016		5.'SEX 1 M 2 A F	6. AGE (In yrs. la:	st birthday) YRS.	IF UNDER 1		IF UNDER	R 24 HRS.	7. DATE	OF BIRTH), Day; Year) 2,19		8. BIRTI	HPLACE (State or Foreign
OB	90. FACILITY NAME (# not in Northwest	Hospi		er		96. СІТУ, 1 R			on of DE					DEATH
DIRECTOR	RESIDENCE OF DEC	la. STATE 10b. COUNTY			10c. CITY, TOWN OR LOCATION Reisterstown									10d. INSIDE CITY LIMITS? 1 YES 2 X NO
FUNERAL	100. STREET AND NUMBER 219 East Cherry Hill Rd.						101, 2	211		10g. CITIZEN OF U.S.				
8	11. MARITAL STATUS 1 □ Never Married 2 A Married 3 □ Widowed 4 □ Divorced 12. WAS DECEDENT EVER IN U.S. FORCES? 1 □ YES 2 ₹ IF YES, GIVE WAR OR DATES				NO	MED 13. WAS DECENDENT OF HISPANIC ORIGIN If yes, specify Cuben, Mexican, Puerto 1 YES 2 M NO Specify:								E American Indian, k, White, etc.
APLETED	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)				CEDENT'S live kind of the Do NOT un USEW		UPATION ring most	of working	ng	4500	KIND OF BUS	X1	DUSTRY	
BE COMPL	17. FATHER'S NAME (First, Middle, Last) Aubrey Crytzer 18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary L. Fitzgerald													
101	19e. INFORMANT'S NAME (Type/Print) 19e. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 W. Chestnut Hill Lane, Reisterstown, Md. 21136 20e. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of													
1 3	20a, METHOD OF DISPOSIT 1 Durial 2 Crematic 4 Donation 5 Other	(Specify)				the Rede	emer	Ce			20c. LO /95 Ba	CATION —	ore,	own, Stata Md.
	21. SIGNATURE OF FUNSIPA	SERVICE LIC	had	4		E	ckha	rdt		eral	Chape		inna	21117 Mills. Md.
	Approximate interval Between Onset and Death IMMEDIATE CAUSE (Final disease or condition resulting in death) But TO (OR AS A CONSCOURNCE OF): Approximate interval Between Onset and Death DUE TO (OR AS A CONSCOURNCE OF):													
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. YCENAL FAILUE 2 WEEKS DUE TO (OR AS A CONSEQUENCE OF):													
اب	PART II. Other algolitics			death but not i	resulting	In the unde	orlying o	ceuse (given in	Part I.	24a. WAS AN PERFOR		24b	WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO
MEDICA	OSTE										1 TYES 2	No		OMPLETION OF CAUSE OF DEATH?
PHYSICIAN:	DID TOBACCO U 25. WAS CASE REFERRED TO EXAMINER? 1 YES 2 PNO		HOSPITAL:	26. PLAC	E OF OEAT	TH (Check on	y one)							
ву РНҮ	27. MANNER OF DEATH 1 Netural 5	Pending Investigation	28a. OATE OF (Month, D	INJURY	28b. TIM	4 Nursin	Bc. INJUR WORK 1 YES	Y AT			(Specify) CRIBE HOW II	NJURY OC	CURED	
TED	3 Suicide 8	Could not be determined	28e. PLACE O building,	F INJURY — At ho atc. (Specify)	me, farm, s	street, tactor	, office			281. LOCA City o	TION (Street a or Town, State)	and Number	r or Rural F	Route Number,
COMPLE			CIAN: To the best of R: On the besis of a:) end manner as stated.
TO BE C	296. SIGNATURE AND TITLE	14.5	RAOI					O		416		D	ECET	(Month, Day, Year) TBER 13,95
Ē	30. NAME AND ADDRESS OF		COMPLETEO CAUS	ORTHU	M 27) (Type,	Print)	920	ITP	4 4	CE	NTER	L.R	An(DALLSTOWN

DHMH-16 Rev 1/89



iges 1, 2, 3 should

TO THE HOSPITAL TO THE FUNERAL C be filed within 72 h

2

31. DATE FILED (Month, Day, Year)

HOSPITAL

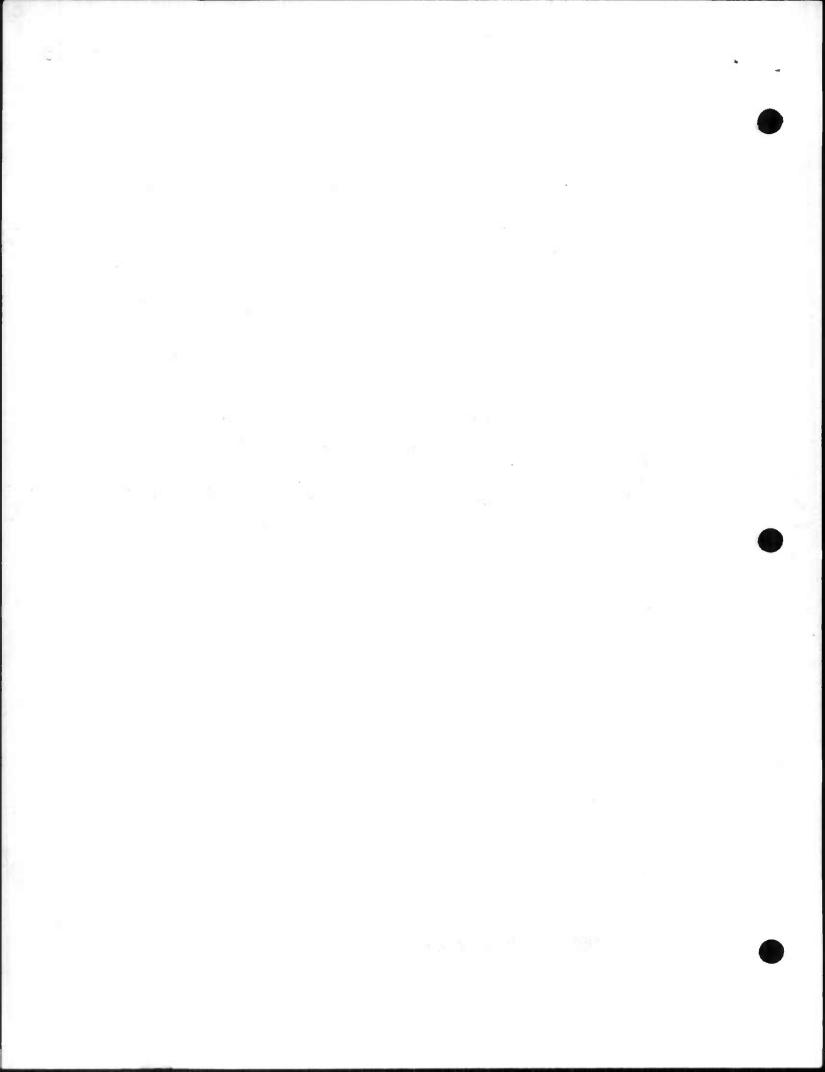
DIVISION OF VITAL RECORDS, P.O. BOX 68760

OR ATTENDING PHYSICIAN: The law requires that the chean conficue be executed within a hours after death. Place 6 may be retained by the hospital or attending physician.	DIRECTOR: After this certificate has been sugared by the attending physician and completely liked in by the furnam director, page 5 should be detached for use as the burial-transit permit. Phous after death with the State Dent, of Health, and Mental Hugers plant to burial companies, or remove	
by the hospital	be detached for	at once.
be retained	ge 5 should	e notified
upe 8 may	finector, pay	r must b
er death. Pr	The fumeral	i examine
A hours an	cian and completely filled in by the or to burial, compation, or remove	ne medica
ted within 2	completely tal, crematic	event, th
de be execu	prior to bur	traumatic
ath certifica	Rending phy	or other
that the de	ed by the a	any injury
aw require	s been sugn	3 shows
CIAN: The I	rtificate ha	or Item 2
ING PHYSIC	offer this ce	marked,
OR ATTENOI	DIRECTOR: After this certificate has been signed by the attending physicism hours after death with the State Deor. of Result and Mental Hugger poor to	Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

95 38059 STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Lest) 2. DATE OF DEATH 3. TIME OF DEATH ANTOINETTE DIGRISTINE DEC 995 7:20 4. SOCIAL SECURITY NUMBER B. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year, 8. BIRTHPLACE (State or Foreign 1 M 2 7 F HOURS 220-12-7274 April 14,1904 Maryland 9a. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH Meridian Nursing Home DIRECTOR Catonsville Baltimore RESIDENCE OF DECEDENT 10e. STATE 10b. COUNT 10c CITY TOWN OR LOCATION 10d. INSIDE CITY Maryland Baltimore Baltimore 1 YES 2 X NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 5930 Sunset Avenue 21207 U.S.A. 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If was asselfy Cuben, Mexican, Puerto Rican, etc.) 11. MARITAL STATUS 12. WAS DECEDENT EYER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☑ NO IF YES, GIVE WAR OR DATES 14. RACE — American Indian, Black, White, atc. If yes, specify Cuban, Mexican, Puerto Ri
1 ☐ YES 2 ☑ NO Specify: 1 Never Married 2 Married BY 3 X Widowed 4 Divorced Specify: White 16a. DECEDENT'S USUAL OCCUPATION

What of work done during most of working COMPLETED 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only hig (Give kind of work done life. Do NOT use retired.) entary/Secondary (0-12) College (1-4 or 5 +) 8 Sales Retail 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Jospeh Libertini Delizia Restivo BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADORESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Delizia Kerler (Daughter) 5930 Sunset Avenue Baltimore, Maryland 21207 20a. METHOD OF DISPOSITION
1 □XBurlal 2 □ Cremation 3 □ Removal from State 20b. PLACE AND DATE OF DISPOSITION (NOTE & 16, 1995 20c. LOCATION — City or Town, Stata Holy Redeemer Cemetery Baltimore, Maryland 4 Donation 5 Other (Specify) 21. SIGNATURE OF FUHERAL SERVICE LICENSE 22. NAME AND ADDRESS OF FACILITY Leroy M & Russell C Witzke Funeral Homes usable cen 1630 Edmondson Avenue Catonsville, Maryland 23. PART I. E ter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, snock, or heart failure. List only one cause on each line. intarvai Betwe IMMEDIATE CAUSE (Final Onset and Death disease or condition AS DIVATION DUE TO (OR AS A CONSEQUENCE OF): neumonia ew days resulting in death) CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediata cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events DUE TO (OR AS A CONSEQUENCE OF)resulting in death) LAST PART II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part i. PHYSICIAN: MEDICAL 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE Mellitys 1 TES 2 100 OF DEATH? Dladdor, Demo 1 - YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL OTHER:
4 Nursing Home 5 Rasidence 8 Other (Specify) 1 YES 2 NO Ninpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 28b. TIME OF 28d. DESCRIBE HOW INJURY OCCURED 1 Natural 1 YES 2 NO BY Accident 28s. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 8 Could not be 4 Homicide 1 💆 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and menner as stated. (Check only one) 2 MEDICAL EXAMINER: On the basis of axamination end/or investigation, in my opinion, death occured at the lime, data end place, and dua to the cause(e) and menner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIES 29c LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE December 13, 1995

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Typo, Pring).
GETHA RAJA 43-57-HOLLING FERRY Rd



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental H Certificate of Death

Hygiene	9	5	3	8	0	6	

3. Time of Death

2. Dete of Deeth Month

Physician
/Medical
Examiner

1. Decedent's Neme (First, Middle, Last)

Funer Directo

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mentel hygiene. Important: If Item 27 is marked other than "natural", or items 23s or 28s-1 show eny Injury or other traumatic event, the Medical Examines Invest be notified at

Baltimore, Maryland 21215-0020

Physicia /Medica Examine

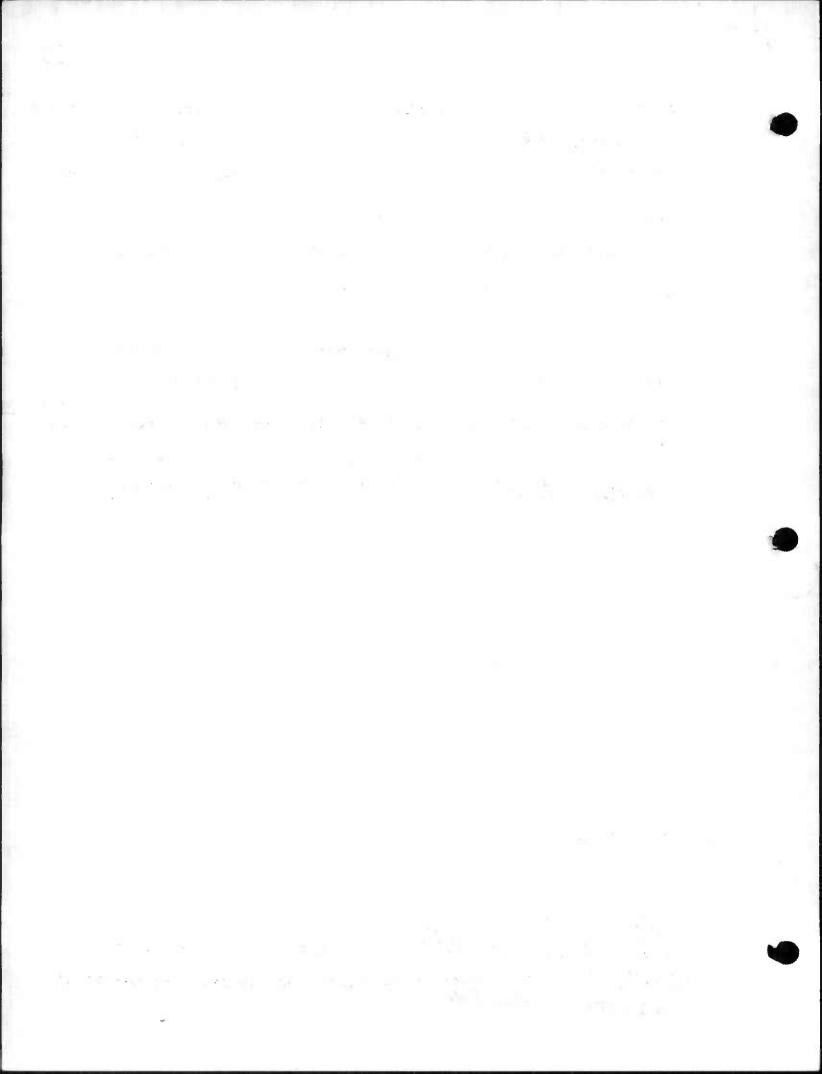
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours effect death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be deteched for use as the buriel-transit

Division of Vital Records, P.O. Box 68760,

ian ical	JENNIE		DeHAAN						Dey 6,1995	Year	06:22 A		
iner	4e. Fecility Neme (If not Institution, gi				4			cation of Death	4c. County				
-	5 3 0 1 WESTPATH 5. Sociel Security Number 6.		s. last birthday	If Under	1 Vear	BETI If Under 2			MONTO				
l r		1 M 2 F	7 4 Yrs.	Months	Deys	Hours	Min.	8. Dete of Birth (Month, Day Jan.	Year) 21,19		iece (State or Foreig try) M I		
1	10a. Stete 10b. County	10c. (City, Town or Lo	ocation						1	0d. Inside City Limits		
Director	MI KENT		В	YRON							1 ☐ Yes 2/☐ No		
- je	10e. Street and Number			10f. Zip	Code			1	log. Citizen of V	What Cour	itry?		
<u>e</u>	698 GARDENVIE	EW DR, SW		4	950	19			U.S.A.				
Funeral	11. Maritel Stetus	11. Maritel Stetus 12. Wes Decedent Ever In Armed Forces?					in? (Spe	clfy Yes or No- Rican, etc.)	14. Rec	e - Americ k, White,	an Indian,		
p	1 □ Never Merried 2 □ Married 3 □ Widowed 4 □ Divorced	1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Detes:		1□Yes 2		Specify:		,	Specify	e.	ITE		
ie d	15. Decedent's E (Specify only highest gr		16a. Dece	dent's Usuel	Occupa	ation	of works	00	16b. Kind of Bu	usiness/înd	dustry		
Completed	Elementery/Secondery (0-12)	College (1-4or 5+)	life.	DO NOT use	e retired)	OF WORKS	ng					
000	8		Н	OMEMA	KEF	\			OWN F	HOME			
Be (17. Fether's Neme (First, Middle, Last	t)				18. Mothe	r's Neme	(First, Middle,	Meiden Suman	10)			
TO E	THIEL BERKEN	IPAS					MAT	TIE SL	OT				
[19e. Informent's Neme/Relationship	(Type, Print)	19b. Maili	ng Address	(Street	and Numbe	r or Rura	I Route Numbe	r, City or Town,	Stete, Zip	Code) 49315		
	MARY BREDEWEG	DAUGHTER						h West					
	20e. Method of Disposition	20b.	Plece of Dispo	osition (Nem	e of				20c. Location -				
	1 ☑ Buriel 2 ☐ Cremetion 3 ☐ 4 ☐ Donetion 5 ☐ Other (Speci				•	,	1	12-11	DODD I	NIA C D	M.T.		
	21. Signeture of Europeal Service Lice		DORR	2. Neme end				12-11	DORR 7	LMSP	, MI.		
	1 William	1/2/10	S	TERLI	NG	ASHT	ON	FUNERA	L HOME	E, IN	С.		
-	23a Part Enter the disease or con	policetions that counsed the de	oth Do not on	36 EI	MON	DSON	AV	E. BAL	TO, MI	2	1228 Approximete		
	23a. Pert1. Enter the disease, or con shock, or heart feilure. List only	one ceuse on each line.	our. Do not on	tor the mode	or dynn	g, 3001 63 t	Darronec o	i respiretory arr	ost,		Interval Between Onset and Death		
	Immediate Cause (Final	1/to	f . 1.	0	. 1		1	1					
	disease or condition resulting in deeth)	· THENDS	ent	E Cox	10 A	DVESC	ylay	- Dis	Case				
6		Due to	(or es e conse	quence of):									
nin	_	b											
Examiner	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury	Due to	(or es e conse	quence of):						j			
	cause. Enter Underlying Ceuse (Disease or injury	C											
dic	thet initieted events resulting in deeth) Lest	Due to	(or es e consec	quence of):									
Me	L	d											
ician/Medical													
ysic	Pert II. Other significant conditions	contributing to death but not re	esulting in the u	inderlying ca	use give	en in Pert I.		23b. Did to	obacco use co	ntribute to	the cause of death		
/ Physi								1 🗆 Y	es 2 No	3 Prof	oably 4 Unknow		
d by								24a. Wes e	n autoney	24h W	ere autopsy findings		
ete								perfor	med?	av	eileble prior to		
Completed								1.0		of	death?		
								1 Y	es 2 No	1/2	Yes 2□ No		
Be	25. Wes case referred to medical examiner?	Hamital			0		of Deeth	(Check only or	10)				
ို	1)X Yes 2 No		☐ ER/Outpatie			4 LI Nui	sing Hon		ence 8 □Oth		/)		
on:	27. Manger of Death 1/⊠Naturel 5 □ Pending	28e. Dete of injury (Month, Dey Year)	28b. Time o Injury		Bc. Injury Work			28d. Describe h	ow injury occur	red			
Sati	Accident Investigation	on		М		Yes 2□N	10						
Certification:	3 Suicide 6 Could not be determined	28e. Plece of Injury - At building, etc. (Spec	home, ferm, st	reet, factory,	offica		2	28f. Location (S City or Town		er or Rura	l Route Number,		
C	29e. Certifier 1□ Cartifying Pt	hyelcfan: To the best of my kr	nowledge deat	h occurred e	t the tim	e dete end	f place e	and due to the c	ause(s) and me	anner as si	ated		
Medical	(Check enly one) Medical Example (Check enly one)	miner: On the basis of examined and menner steted.	netion end/or In	vestigation,	in my op	inlon, deet	h occurre	ed et the time, d	ete end plece,	end due to	the cause(s)		
Me	29b. Signature and title of certifier	1	\wedge	29c.	License	number		2	9d. Dete signe	d (Month,	Dey, Year)		
	Van	177h 0 AM	()		00	TME		-	EC 07	100	5		
	30. Name and address of person who	completed cause of death (the	m 23a) /Type	Print)	OC	CME		L	EC.07	, 199	J		
	(TIARAN LA	CKE MI	11 Do	n C+-	ro 04	- R=	1+4	moro	Marul	has	21201		

State Registrar DEC 1 5 1995



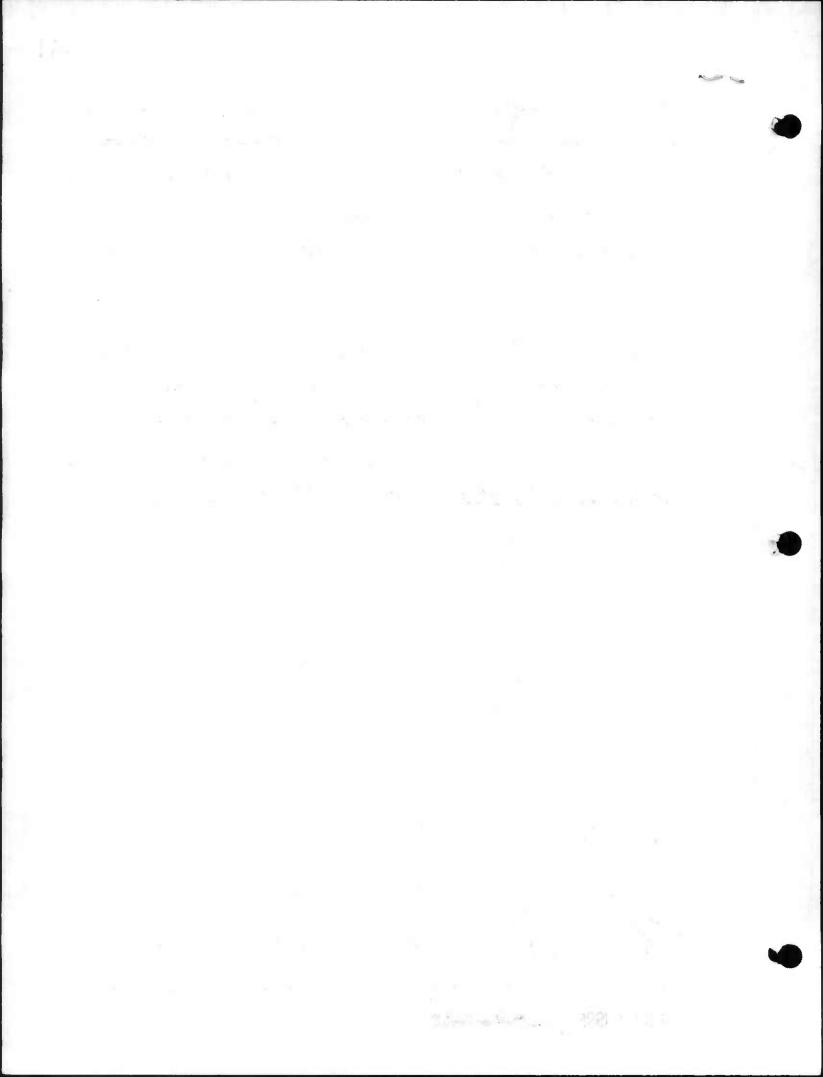
State of Maryland / Department of Health and Mental Hygiene 95

95 38061

						Certificate o	Dealli		Reg. No.			
	Physici	an	1. Decedent's Neme (First, Middle, L.					2. Dete of De	eth Dey	Year 3	. Time of Death	
	/Medi		Robert Edward			France		Dec.		995	12/100	
بز	Examir	ner	4e. Facility Neme (If not institution, given 2421 Rockwell				4b. City, Town, or Lo			of Death		
	Funeral Director		5. Social Security Number 212–10–3339 6.	Sex 7. Ag	ge (In yrs. lest birth 88 Yr	Months Day		8. Dete of Birt (Month, De Sept. 3	th y, Year) 0,1907		e (Stete or Foreign	
	show od at		Usuel Residence of Decedent 10a. Stete 10b. County		40. Oh. Ta	-1						
		ក្ន	Md. Baltin	ore	10c. City, Town	Catonsvi]	110				Inside City Limita 1 ☐ Yes 2 ☐ No	
	28e L	Director	10e. Street end Number	OLC .		10f. Zip Code		10g. Citizen of What Country?				
1	23a or	rai Dir		Avenue		2	21228			J.S.A.		
21215-0020	illed within 12 hours after deeth with the Maryland Hygiene. Ither than "natural", or items 23a or 28e-f show int, tre Medical Examiner must be motified at	by Funeral	11. Meritel Stetus 1 Never Merried 2 Married 3 XVidowed 4 Divorced	12. Wes Decedent Armed Forces? 1 ∑Yea 2 ☐ If Yes, Give Yeer or Detea:		13. Wes Decedent of If Yes, specify Cu 1 ☐ Yes 200	i Hispanic Origin? (Spuben, Mexican, Puerto o Specify:	ecify Yea or No Rican, etc.)	Specif	e - American I ck, White, etc. v: Whi		
15-0	"netu	Completed	15. Decedent's E (Specify only highest g	ducation ade completed)	16a. D	ecedent's Usual Occ Give kind of work don	upetion e during most of work red)	ing	16b. Kind of B	usiness/Indust	ry	
212	r then	ошо	Elementery/Secondery (0-12)	College (1-4or	5+)	Auditor				Insurance		
pu	2 should be filed withing and Mental Hygiene. a marked other than aumstic event, tre. Mental tre.	Bec	17. Fether's Neme (First, Middle, Las	•			18. Mother's Name			n <i>e)</i>		
yla	should be tiled and Mental Hygi markad other matic event, i	To	Robert Edward Fr				Unknown	Mcl	Kenzie			
2	permif. Pages 1 and 2 should Department of Health and Men Important: if Item 27 Ia marka any Injury or other traumatic pnce.		19e. Informent's Neme/Reletionship Gloria MacKay	(Type, Print)				Aural Route Number, City or Town, Stete, Zip Code) ott City, Maryland 21042				
See .			20a. Method of Disposition 1 ☑ Buriai 2 □ Cremetion 3 I		1	Disposition (Name of cremetory or other p		Dete	20c. Location			
Balti	ortan Injur		4 Donetion 5 Other (Specify) St. John's Cemetery Dec. 16, 1995 Ellicott City, Md. 22. Name and Address of Facility									
n	Depa impo any i		Kungea	(n) - X			Russell C				2	
-	-		23a. Pert1. Enter the disease, or cor shock, or heart feilure. List only	nplications that ause	the death. Do no	t enter the mode of d	ndson Avenu ylng, such es cardiac	or respiretory er	nsville resi,	Ao	proximete	
All	hysician /Medical Examiner		Immediate Cause (Finei disease or condition resulting in death)	o. Myc	Due to (or as a co	al Tha	rition	. 61			erval Between neet end Deeth	
7	sit ed	Examiner		b								
68760,	physician and sthe burial-transit	Ехап	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury		Due to (or es a co	nsequence of):						
68760,	ysicia ne bur		thet initiated events	C				i				
89	0 6	Medical	resulting in deeth) Lest									
Box		Physician/		d						l		
	0 0	sic	Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.						tobacco use co	ntribute to the	e cause of death?	
s, P.	n signed by the a	by Phy						10	Yes 2 No	37 Probabl	ly 4 Unknown	
I Records, P.O	s been si	Completed							en eutopsy med?	availat	eutopsy findings ble prior to etion of cause th?	
Re	ata has	шо						101	res 2/2 No	1 🗆 Ye	_	
		Bec	25. Wes case referred to medical				26. Plece of Deetl					
of Vita	0 G	70	examiner? 1 ☐ Yes 2⊠ No	Hospitei:	ent 2 ER/Outp	etient 3 DOA	ther: 4 Nursing Ho			er (Specify)		
Vision o	After The Property of the Prop		27. Menner of Deeth 1 Xivetural 5 Pending 2 Accident Investigation	28a. Dete of Inju (Month, De	ry 28b. Tin y Year) Inju	ıry W	ury et ork? ☐ Yes 2 ☐ No	28d. Describe I	now injury occur	red		
= >	after death. Director: A d in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not I determined		ury - At home, ferm c. (Specify)	street, fectory, office	8	28f. Location (S City or Tox	Street and Number, Stete)	per or Rural Ro	oute Number,	
Lephanite	4 hours Funeral taly fille	edical C	29e. Certifier (Check only one) (Check only one)	miner: On the basis of	exemination and/o	deeth occurred at the or Investigation, In my	time, dete end plece, or opinion, deeth occurr	end due to the ded et the time,	cause(s) end mo	enner as stete	d. e ceuse(s)	
£	within 2 To the compla	Med	29b, Signature and title of certifier	end manner ste	eled.		nse number		29d. Dete signe			
	¥ F 8		(taling (N/hlute	M, C		23365		12/1	4/95	-	
	10		30. Name and address of person with	completed cause of d						1		
	Sta	te	31. Dete filed (Month, Day, Year)	32. Registr	7/CMF er's Signeture	HOENCHO	DICE CA B	ALTO	mo 2	1228		

DHMH 16 Rev 6/95

State Registrar



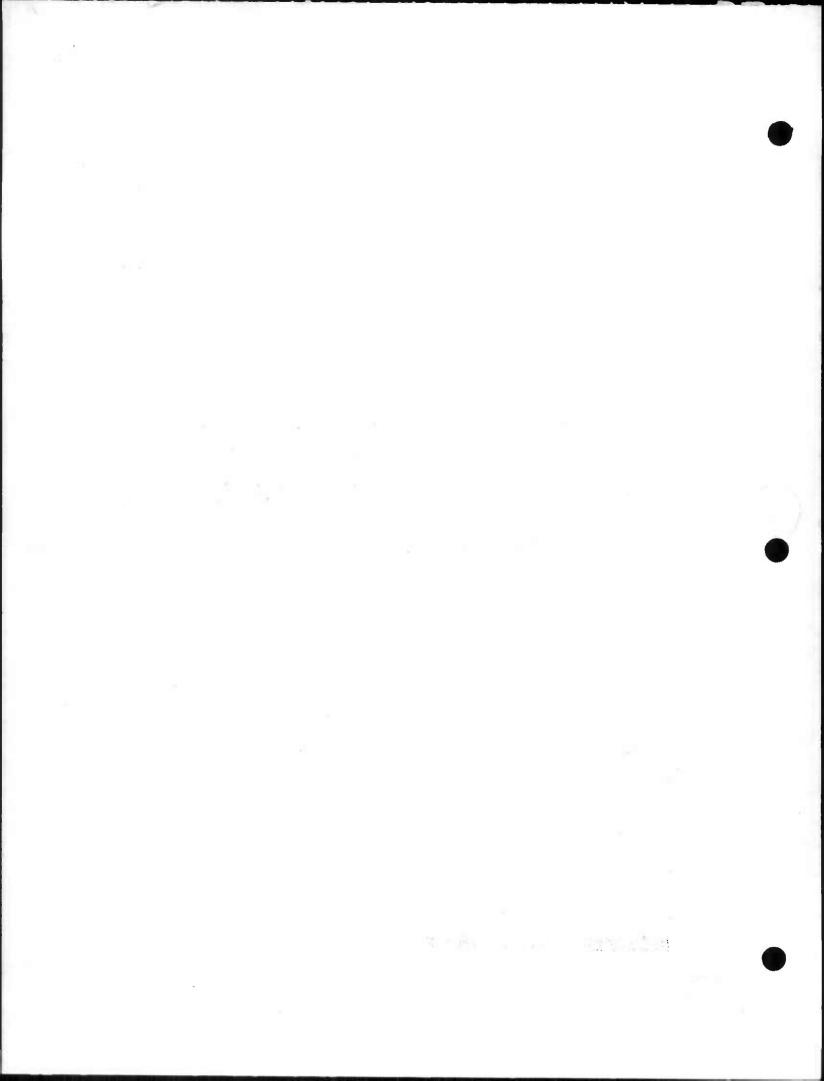
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physician.	burial-transit
attending .	hed for use as the bi
ne hospital or attendi	detached for
ained by th	hould be
may be ret	page 5 s
Page 6	al director
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E S	ŀ
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executed with	and completed
te be	rsician a

DIVISION OF VITAL RECORDS, P.O. BOX 68760

it. Pages 1, 2, 3 should TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within the companient of the control of the state of

	FOR 1 - STATE REGISTRAR	STATE OF M					EALTH AND N	MENTAI	REG. NO.				
	1. DECEDENT'S NAME (First, Middle, Last)	******						MONTE	OF DEATH	1005	YEAR	3. TIME OF DEATH	
		Edith N	8. AGE (In yrs. In		Les IF UNDER	VEAD	IF UNDER 24 HRS.		с 13,		BIOTHO	11 P M	
	215-46-1125	1 □ M 2 XXF	85	YRS.	MONTHS	DAYS	HOURS MIN.	Dec	6, 19	910 Penna.			
~	So. FACILITY NAME (If not institution, give stre						R LOCATION OF DE	ATH		9c. COUNT		ATH	
DIRECTOR	Union Memori	al Hospi	ital		Ва	lti	more			N	/A		
<u>E</u>	10e. STATE 10b. COUNTY			10c. CIT	Y, TOWN O	R LOCAT	ION					IOd. INSIDE CITY	
E	Maryland N	I/A_		Baltimore								LIMITS?	
	10e. STREET AND NUMBER					101.	ZIP CODE			_		IAT COUNTRY?	
FUNERAL	810 West 36th	Street 21211						U	.S.A				
5		12. WAS DECEDEN	T EVER IN U.S. A	U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Spec 2 ℃ NO 15 yes, specify Cuben, Maxicen, Puerto Rican, e						or No-	14. RACE -	- American Indian, White, etc.	
BY F	1 Never Merried 2 Married 3 Widowed 4 Divorced	AR OR DATES				2 NO Specify		110011, 0101,			White		
	15. DECEDENT'S EDUCA	ATION	1 480 0	ECECENTIC	l lieuw oo	OLIDATIO	. Ad	1 464	KIND OF BUILD	NESS (NO.	e Troy		
1	(Specify only highest grade c	ompleted)	- S	18e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF					, KIND OF BUS	INESS/INDU	SINI		
1	Elementary/Secondery (0-12)	College (1-4 or 5	+)	Homemaker Own Hom						ome			
COMPLETED	17. FATHER'S NAME (First, Middle, Lest)				16, MOTHER'S NA	ME (First, I	Middle, Maiden S	Surneme)					
Ö	Silvio					Ann	_	11ick					
BE	19e, INFORMANT'S NAME (Type/Print)	9b. MAILING	ADDRESS	(Street e	nd Number or Rural I	Poute Numi	ber, City or Town	, Stete, Zip (Code)				
2	Georgene Brodie 2217 Foxbane Sq., Baltimore, Maryland 21209										1209		
	206. METHOD OF DISPOSITION 206. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION — City or Town, Start												
	4 ☐ Donetion 5 ☐ Other (Specify)	val from State	- Warf	rematory or d	Cemet	ery		12/	15 Je	ssup,	Mar	yland	
	21, SIGNATURE OF FUNERAL SERVICE LICE	NSEE	10		22. I	NAME AN	D ADDRESS OF FA	CILITY	Euro	1 D	lomo		
	> a alam	Seite	.(h				an Seitz Roland A					id 21211	
	23. PART i. Enter the disesses, or co	mplicetions the	t ceused tha c	laeth. Do								Approximate	
	ahock, or haart fallure. L. iMMEDIATE CAUSE (Final			ne.								Onset and Death	
	disease or condition resulting in death)	Colore	UTA	Ca	hoen							Yyrs+3mus	
	DUE TO (OR AS A CONSEQUENCE OF):												
Z	Sequentially list conditions, D. DUE TO (OR AS A CONSEQUENCE OR)												
M	or the property of the propert												
2	CAUSE (Disease or Injury C. C. CONSTOLISMS OF A CONSTOLISMS OF												
E	that initiated events DUE TO (OR AS A CONSEQUENCE OF): resulting in death) LAST											İ	
CERTIFICATION	- 0	•				1-11						+	
긡	PART II. Other aignificant conditions	contributing to	death but not	resulting	in the un	derlying	g cause given in	Part I.	24a, WAS AN PERFOR			WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO	
20									1 TYES 2	X NO		COMPLETION OF CAUSE OF DEATH?	
MEDIC/							/		· ·		111	1 TYES 2 NO	
ä	DID TOBACCO USE CONTR	IBUTE TO CA					UNCERTAI	и 🗆					
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PL/	ACE OF DEA	OTHER								
YSI	1 TYES 2 NO	1 Inputient 2		_	4 🗆 Nuri	lng Hom		_	er (Specify)				
	27. MANNER OF DEATH 1 X Natural 5 Pending	28e. DATE Of (Month, L		28b. TII	WE OF JURY		RK?	28d. DE	SCRIBE HOW II	NJURY OCC	URED		
BY	2 Accident Investigation	280 DI ACE (OF INJURY — At I	home town			YES 2 NO	201.100	CATION (Street o	and Abamban	as Durent Co	nuto Alvienbos	
ED	3 Suicide 8 Could not be 4 Homicide determined	building	etc. (Specify)	nome, term,	atropt, race	ory, orne			or Town, State)	na number (or numer n	odie Nottioes,	
COMPLETED	29e. CERTIFIER			-200	VILVA G TO				active a		_		
MPI	(Check only	_										and monner on stated.	
00		t. Of the best of t	- Administration whose	n mreetigat	ion, in my o	prinon, d			a and place, en				
BE	29b. SIGNATURE AND TITUE OF CERTIFIER),					29c. LICENSE NUI	MBER			SIGNED	(Month, Day, Year)	
2			SE OF DEATH OF	IEM 270 /5-	a Print		171 3079	6		- 10	V-12.	77	
ERIC ROWINING M-D. JOHNS HOMIN OK CER BOLTH									7 more	, mr),		
	31. DATE FILED (Month) DAY 1995	A RECESTR	AR'S IGNATURE										





ITEM: 19b, PER F.H. FILM G-730 12/12/95 t.t

		FOR STATE REGISTE
i	I	1. DECEDENT'S
	١	Y
	ı	4. SOCIAL SEC
	i	213-2
	l	9a. FACILITY N
		Picl
1	ı	RESIDENCE
	1	10a. STATE
		MARYL
ı	NF	10- STORET AL

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAR		CERTIF	ICATE O	F DEATH	В	EG. NO			
	1. DECEDENT'S NAME (First, Middle, Last)		0.11	-		2. DATE OF	DEATH			3. TIME OF DEATH
	MAYION HO	shall (GILL	_		Dec.	11	1995	YEAR	6:50 AM M
	4. SOCIAL SECURITY HUMBER 5. SEX		yrs. last birthday)	IF UNDER 1 YEA	R IF UNDER 24 HRS.	7. DATE OF E		1990	0 51551	PLACE (State or Foreign
	213-20-5872			MONTHS DAY		(Month, De	v. Year)		Countr	γ)
	-13 10 3011	44	95 YRS.			June 2	6, 1	1900 MARYLAND		
~	9a. FACILITY NAME (If not institution, give street and nu	mber)		9b. CITY, TOW	N DR LOCATION OF O	EATH		9c. COUNTY OF DEATH		
Ö	Pickersgill Nursing	Home		TO	WSON			BAL	TIMO	RE
<u>[</u>	10a. STATE 10b. COUNTY		T 40. 017	V 70000 00 10						
<u>E</u>		-		Y, TOWN OR LO	CATION					10d, INSIDE CITY LIMITS?
	MARYLAND BALTIMOR	E		TOWSON						1 TYES 2 NO
¥.	10a. STREET AND NUMBER		10f. ZIP CODE					10g. CIT	ZEN OF Y	VHAT COUNTRY?
BY FUNERAL DIRECTOR	615 Chestnu	t Avenue	1e 21204						USA	
5		DECEDENT EVER IN	R IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC				pecify Yes	or Ho-	14. RACE	- American Indian,
>	1 Never Married 2 Married IF YES	B, GIVE WAR OR DAT	ES ZYO	1 🗆 Y	specify Cuban, Maxica ES 2 □XiO Specifi		1, etc.)			t, White, etc.
	3 X Wildowed 4 Divorced				VI -440 00110				WHI	ŤE
E I	15. DECEDENT'S EDUCATION (Specify only highest grade completed)		16a, DECEDENT'S	USUAL OCCUPA	TION	16b. KIH	O OF BUS	SIHESS/INC	DUSTRY	
<u> </u>		(1-4 or 5 +)	ille. Do NOT us	e retired.)	most or working					
AP I	8 n/a		Hom	emaker		0	wn H	lome		
COMPLETED	17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NA		_			
	John Wesley G	ore			Minni	e Blan	aha	Uooh	011	
B	19a. IHFORMANT'S NAME (Type/Print)	OTC	196. MAILIHO	ADDRESS /Stree	at and Number of Bural					
2	Edward W. Cooper									
	20a. METHOD OF DISPOSITION	- I -			Crest Rd.					
	1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place)								wn, State	
	4 Donation 5 Other (Specify)	D D	ulaney	Valley	Mem.Garde	nsDEC	Tim	oniu	m, M	D
	- 1 X9994 12KG				AND ADDRESS OF FA		0 0 6	D., 1	00011	Vol10 Tm.
Lowell Lemmon Funeral Home of Dulaney V. 10 W. Padonia Rd., Timonium, MD										
	23. PART I. Enter the disesses, or complicati	ons that caused	the deeth. Do r	of enter the r	W. I dului	d Nu.,	I III	OHTU	III e III	
	enock, or neert failure. List only	one cause on sac	ch line.		nous or dying, sec	in se cerurec	or respi	ratory arr	wet,	Approximats Interval Batween
	IMMEDIATE CAUSE (Final disease or condition	1 1+	2 /	1		1- "	1.	1		Onset and Death
	resulting in desth) s	Legi	Ceru	NO UAS	sculm	ACCI	cen	1		10dm
ł		DUE TO OR AS A	CONSEQUENCE OF	f):						
8	Sequentially list conditions,									
CERTIFICATION	If any, lesding to immediate	DUE TO JOH AN A C	COHSEQUENCE OF	f):						
<u> </u>	cause. Enter UNDERLYING CAUSE (Disesse or injury									
Ë I	thet initiated events resulting in death) LAST	DUE TO (OR AS A C	CONSEQUENCE OF	ን:						
E	d									
	PART II. Other significant conditions contribu	iting to death but	t not resulting	n the underly	Ing course alven in	Dort I or	WM 0 411	AUTOPSY	Lau	
DICAL	1+TPO thyro				mg cadeo given in	248	PERFOR		240.	WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
	11001070	10.13	/			10	YES 2	НО		COMPLETION OF CAUSE OF DEATH?
¥.						_				1 - YES 2 - NO
ä	DID TOBACCO USE CONTRIBUTE	O CAUSE OF	DEATH YE	S I NO	UNCERTAIN	N 🔲				
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?		B. PLACE OF DEAT		10)					
is I	_ nosri	ant 2 ER/Outpet	lent 3 DOA	OTHER:	ome 5 🗆 Rasidence	6 Other (Spi	ecify)			
ξI	27. MAHHER OF DEATH 28s.	DATE OF IHJURY	28b. TIM	E OF 28c. I	NJURY AT	28d. DESCRIE		JURY OCC	CURED	
BY F	1 X Natural 5 Pending	Month, Day, Year)	IHJ		WORK? YES 2 HO					
	3 Suicide e Could 28e.	PLACE OF INJURY -	- At home, ferm, s	treet, tactory, of	fice	28f. LOCATION	N /Street a	nd Number	or Burel S	nuda Alumbar
	4 Homicide Getermined	building, etc. (Specif)	1)		-	City or Tox	wn, State)	ing ivolinger	OF FILMENTS	oute Hornow,
91	29e. CERTIFIER									
를	(Check only 1 CERTIFYING PHYSICIAH: To the									
COMPLETED	2 MEDICAL EXAMIHER: On the b	sele of examination a	and/or investigation	n, in my opinion	, death occured at the	time, data and	place, and	dua to th	e cause(a)	and menner as stated.
w II	296. SIGNATURE AND TITLE OF CERTIFIER	10			29c. LICEHSE HUM	4BER		29d. DATE	E SIGHED	(Month, Day, Year)
ω II	SI- Hastons 1	din .	my		1725	205		1/	2/11	195
유	38. NAME AND ADDRESS OF PERSON WHO COMPLET	ED CAUSE OF DEAT	H (ITEM 27) (Type.	Print)					1 "	,,,
	J. Anthony Riley, MD	/,			C+ C	4- 210	c			01001
		GISTRAR'S SIGHAT	URE (martes	St., Sui	te 312.), T	owsor	ı, MI	21204
	DECT FACE									
- 1	- U IOOO , when we	when Rade	H							

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with a factor of the control of the control of the control of the standard of the attention of the attention of the attention of the control of the co DIVISION OF VITAL RECORDS, P.O. BOX 68760

BALTIMORE, MARYLAND 21215-0020

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020	L OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physicia	DRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-the bound with the State Dear of Health and Mental Minister ends to burial cremation or removal
	24 hours after	filled in by th
RECORDS, P.O. BOX 68760	v requires that the death certificate be executed within a	been signed by the attending physician and completely or Health and Mental Hymine prior to burial cremative
DIVISION OF VITAL	OR ATTENDING PHYSICIAN: The law	DIRECTOR: After this certificate has been been after death with the State Deet

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, in the Relative State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or Nem 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	1 - STATE REGISTRAR	STATE OF MARYLAN		MENT OF HEALTH AND ATE OF DEATH	MENTAL HYGIENE REG. NO.						
	1. DECEDENT'S NAME (First, Middle, Lest)	HUDGI	NS		2. DATE OF DEATH DAY	9. 1995	NE OF DEATH				
	0.0 00 10110	1 M 2 🗆 F	68 YRS. MO	UNDER 1 YEAR IF UNDER 24 HRS. NTHS DAYS HOURS MIN.	927 Marc	8. BIRTHPLACE (State or Foreign 27) Mary and					
TOR	MERCY HOSPITA	,	31	BALTIMORE		9c. COUNTY OF DEATH					
DIRECTOR	10a. STATE 10b. COUNTY		10c, CITY, T	OWN DR LOCATION			INSIDE CITY LIMITS?				
	MARYLAND N/	A		BALTIMORE 107, ZIP CODE	_	10g. CITIZEN DF WHAT	YES 2 ND				
FUNERAL	6800 LIBERTY RO	AD APT/ 3	-	21.20		2U	Δ				
BY FU	1 Never Merried 2 X Merried 3 Widowed 4 Divorced	FDRCES? 1 X YES	2 NO	If yes, specify Cuban, Maxic	can, Puarto Rican, etc.)	Black, White Specify:	AMERICAN				
COMPLETED	15. DECEDENT'S EDUCA' (Specify only highest grade co	FION 18 mpleted)		done during most of working	16b. KIND OF BUSI						
PLE	Elementary/Secondary (0-12) College (1-4 or 5+) 1-2 College (1-4 or 5+) WECHANICAL ENGR. US GOV					ERNMENT					
COM	17. FATHER'S NAME (First, Middle, Last)	(urname)									
BE	RICHARD HUDGINS BERTHA HUDGINS 196. MAILING ADDRESS (Street and Number or Pairel Route Number. City or Town, State, Zio Code)										
5	196. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) CLIFFORD IRIS HUDGINS 3809. CEDAR DR. BALTIMORE, MD 21207										
	20a, METHOD OF DISPOSITION 1 Devial 2 Cremation 3 Remove		LACE AND DATE OF	DISPOSITION (Name of Place) EMETERY	DATE 20c. LOC	ATION — City or Town, S	tate				
	4 ☐ Donation 5 ☐ Other (Specify)		CITY	22. NAME AND ADDRESS OF F	FACILITY		TENN				
	Dorenk of	Muss			ORTH AVE	BALTO	MD STSTP				
CERTIFICATION	23.DART i. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or reapiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition reautiling in death) DUE TO (DR AS A CONSEQUENCE OF): DUE TO (DR AS A CONSEQUENCE OF): DUE TO (DR AS A CONSEQUENCE OF): DUE TO (DR AS A CONSEQUENCE OF): DUE TO (DR AS A CONSEQUENCE OF): DUE TO (DR AS A CONSEQUENCE OF):										
PHYSICIAN: MEDICAL CERT	DID TOBACCO USE CONTRI 25. WAS CASE REFERRED TO MEDICAL EXAMINER?	ESOPHAGE LESSING BUTE TO CAUSE OF 100 100 100 100 100 100 100 1	MANCO A DEATH YES	esuiting in the underlying cause given in Part I. 246. WERE AUTOPEV PRIFORMEDT VES 2 NO DINCERTAIN DE OF DEATH (Check only one) OTHER:							
HYS	1 TYES 2 ND 27. MANNER OF DEATH	1 Inpetient 2 ER/Outpeti	26b, TIME (a 8 U Other (Specify) 28d. DESCRIBE HOW IN	JURY OCCURED					
ВУ Р	Netural 5 Pending Investigation	(Month, Day, Year)	INJUR	M 1 YES 2 NO							
ED	3 Suicide 8 Could not be 4 Homicide detarmined	28a. PLACE OF INJURY — building, etc. (Specify	- At home, farm, atre	et, factory, offica	281, LOCATION (Street as City or Town, State)	OCATION (Street and Number or Rural Route Number, lty or Town, State)					
COMPLET	CONSTRUCTION OF THE PROPERTY O			at the time, data and place, and d in my opinion, death occured at ti			manner sa stated.				
TO BE C	29b. SIGNATURE AND TITLE OF CERTIFIER MONULI 30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF DEAT	40 TH (ITEM 27) (Type, P	29c. LICENSE N	930 80411 81	29d. DATE SIGNED (Mon	th, Day, Year) Des 9,1975				
	MARVIN T. 1 31. DATE FILED (Month, Day, Year)	TELONA!	Y, MD	Baitin	yore, m	2/20	2				
	the Hudran Partoll	3661 \$ TJ.									



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		Certificate of Death		Reg. No.	95 3	3806				
Physic	ian		2. Data of Da Month			3. Tima of Death				
/Medi	ical		DEC.	1	995	6:43 F				
Examii	ner	4a. Facility Nema (If not institution, give streat and number) 4b. City, Town, or Loc 2906 CHERRYLAND RD. BALTIMO	RE		V/A					
Funeral Director		5. Sociel Security Number 6. Sex 1 Months Days Hours Min. 1 Sugar Passidance of Decedant	8. Data of Bin (Month, Da	2,1974	A 9 puntry	y and				
permit. Feyor I sinc should be lied within 72 hours enter deen with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If them ZY Is marked other than "natural", or items 23a or 28a-f show any injury or other treumatic event, the Medical Exercise; must be notified at ance.	To Be Completed by Funeral Director	10a. State 10b. County Baltimore 10e. Street and Number 2824 Round Rd. 10f. Zip Coda 21225 11. Marital Status 1 Was Decedent Evar in U.S. Armed Forcas? 1 Wevar Marriad 2 Merried 1 Yas, Giva Yaar or Datas: 1 Woevar Marriad 1 Divorced 1 Yas, Giva Yaar or Datas: 15. Decedent's Education (Greatify only highest grada completed) Elemantary/Secondary (0-12) Collage (1-4or 5+) 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. Do NOT use ratired) 17. Father's Neme (First, Middle, Last) 18. Mothar's Nama Peology 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street end Number or Rural 2824 Round Rd 20a. Mathod of Disposition 1 Burial 2 □ Cramation 3 □ Ramoval from Steta 4 □ Donation 5 □ Other (Specify)	cify Yas or No Rican, etc.)	Specification of B Res Maidan Surner Hall Per, City or Town 20c. Location	What Country S A ca - American ck, Whita, atc y: Bla usiness/Indus ta U I ne) Stata, Zip Co d. 2	indian, s. CK stry rant				
		21. Signature of Funaral Sarvice Dicensae. 22. Name end Addrass of Facility 23a. Part Enter the disease, or complications that caused the daath. Do not enter the mode of dying, such as cardiec or shock, or haart failure. List only one cause on each line.	ve. Bo		1d. 21	216 pproximata itarval Batween				
hysician //Medical and published of the prival-transit as the priv	edicai Examiner	Immediate Causa (Final disaasa or condition resulting in daath) a. Multiple Gun Shut Wounds Dua to (or as a consequance of): b. Dua to (or as e consequance of): if any, leading to immediate causa. Enter Underlying Cause (Disaasa or Injury that initiated evants Due to (or as e consequence of):								
C) 65	Due to (or as e consequence of): Due to (or as e consequence of):									
been signed by the should be detached	by Phy		1 🗆 '	Yes 2□ No	3 Probet	oly 4□Unkno				
ate has been signed by the ettendir page 2 should be detached for use	Completed		24e. Was perio	en autopsy emed?	availa	autopsy findings ible prior to lation of causa ath?				
			150	Yas 2□No	1/2Y	as 2□ No				
ector: After this certificate by the funeral director, par	Certification: To Be	1 □ Natural 5 □ Panding (Month, Day Year) Injury Work? 2 □ Accident invastigation 3 □ Sulcide 6 □ Could not be datarmined 4 □ Place of Injury - At homa, ferm, streat, factory, office building, atc. (Specify)	na 5 □ Rasio 8d. Dascribe to Subject 8f. Location (S City or Tow	danca 6 Stoth	red ber or Rural R					
d in t	10		and the same of th		annar as state	ed.				
4 hours after Funeral Dir tely filled in		29a. Certifiar (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred	d at tha tima,	data and placa,	and dua to th	a causa(s)				
	Medical C		d at tha tima,	data and placa, 29d. Dete signe DEC .	d (Month, Da	a causa(s) y, Year)				

DHMH 16 Rev 6/95

in the second of

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State of Maryland / Department of Health and Mental Hygiene

12-26-95 FilmG730 W.H.Per OCME Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death **Physician** DECEMBER 13 1995 7:42 AM **HEPBURN** MARK /Medical 4a. Facility Nama (If not Institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ANNE ARUNDEL PASADENA 691 203rd.STREET H Under 1 Year H Under 24 Hrs. 8. Data of Birth Months Days Hours Min. JUNE 20 5. Social Security Number 7. Aga (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 10 M 20 F Months 216-88-0579 32 Yrs. Director 1963 MARYLAND Usual Rasidance of Dacedant 10a, Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show must be notified at 1 Yas 2 No MARYLAND ANNE ARUNDEL PASADENA Director 10e. Street and Number 10f. Zip Coda 10g, Citizan of What Country? 5 688 203RD STREET 21122 USA 23a Funeral Hems 2 12. Was Decedant Evar in U.S. Armed Forces? 1 ☐ Yas 2 ☐ No If Yas, Giva Yaar or Datas: Was Decedant of Hispanic Origin? (Specify Yas or No. If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - American Indian, Black, Whita, atc. 11. Maritai Status e filed within 72 hours after de Il Hyglene. other than "natural", or Item 1 Nevar Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 No Specify: by Specify: 3 ☐ Widowed 4 ☐ Divorced WHITE Completed 15. Decedent's Education (Specify only highast grada complated) 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 16b. Kind of Businass/Industry Elamantary/Secondary (0-12) Collaga (1-4or 5+) BUILDING CONSTRUCTION DRY WALL INSTALLER marked other permit. Peges 1 and 2 should be file Depertment of Health and Mental Hy Important: If Itam 27 Is marked other any Injury or other traumatic event once. 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Malden Sumama) MARY A. TRIBULL EDGAR A. HEPBURN 19a, Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Numbar or Rural Routa Number, City or Town, Stata, Zip Coda) 688 203RD STREET, PASADENA, MD 21122 MARY A. HEPBURN - MOTHER 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 A Burial 2 Cramation 3 Ramoval from Stata EN HAVEN CEMETERY 12-16 GLEN BURNIE, MD 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signatura of Funeral Sarvice License 22. Nama and Address of Facility STALLINGS FUNERAL HOME, P.A. 0 STALLINGS HILARY L STALLINGS JR
23a. Part 1. Entar the disease, or complications that of used shock, or haart failura. List only one cause or seen line HILARY 3111 MOUNTAIN ROAD, PASADENA, MD
Do not antar the mode of dying, such as cardiac or respiratory arrest, Approximata Interval Between Onset and Death Physician Acute Narcotic Intoxication Immediate Cause (Final disaasa or condition rasulting in death) /Medical Examiner Due to (or as a consequance of): Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, laading to immadiata cause. Enfar Undarlying Ceusa (Diseasa or Injury that initiated evants rasulting in death) Last Dua to (or as a consequence of): and physician aus the burial-t Physician/Medical Dua to (or as a consequance of) attending for use as Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown signed t by 24b. Wara autopsy findings available prior to Completed 24a. Was an autopsy peen complation of causa of death? certificate hes birector, page 2 s 1 Xyas 2□No 1XYas 2□ No Be 25. Was casa rafarred to medical 28. Placa of Death (Check only ona) examinar? Other: 4 Nursing Homa 5 Residence Mother (Specify) SCENE 2 1 Inpatiant 2 ER/Outpatienf 3 DOA this funeral 3a. Date of Injury 0 und 3_05 28c. Injury at Work? 27. Mannar of Death Certification: 28b. Tima of 28d. Describe how Injury occurred 5 Fending invastigation Found At M 1 Natural Unknown -13-95 1 ☐ Yas 2 No 2 Accidant 6 Could not be determined 3 Suicida 281. Location (Street and Number or Rural Routa Number, City or Town, Stata) Pasadena MD

Hospital or Attending Physician: deeth. ector: A by the fi Direc filled in To the Hospital of within 24 hours at To the Funeral C completely filled

(Check only one)

4 Homicida

MO

28a. Place of Injury - At homa, farm, atraat, factory, office building, atc. (Specify)

Found in House

Pasadena, MD. 691 203RD Street 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signatura and titla of certifiar

29c. Licansa number O.C.M.E.

29d. Data signed (Month, Day, Year) DECEMBER 13,1995

30. Nama and addrass of personation complated cause of death (Itam 23a) (Type, Print)

DENNIS J. CHUTE MA 31. Data filed (Month, Day, Year) DEC1 5 1995

111 Penn Street, Baltimore, Maryland 21201

State Registrar

edical

32. Registrar's Signatura ilia Mivileon Ranfall

Division of Vital Records, P.O. Box 68760,

. 3 entropy and the second

DIVISION OF VITAL RECORDS, P.O. BOX 68760

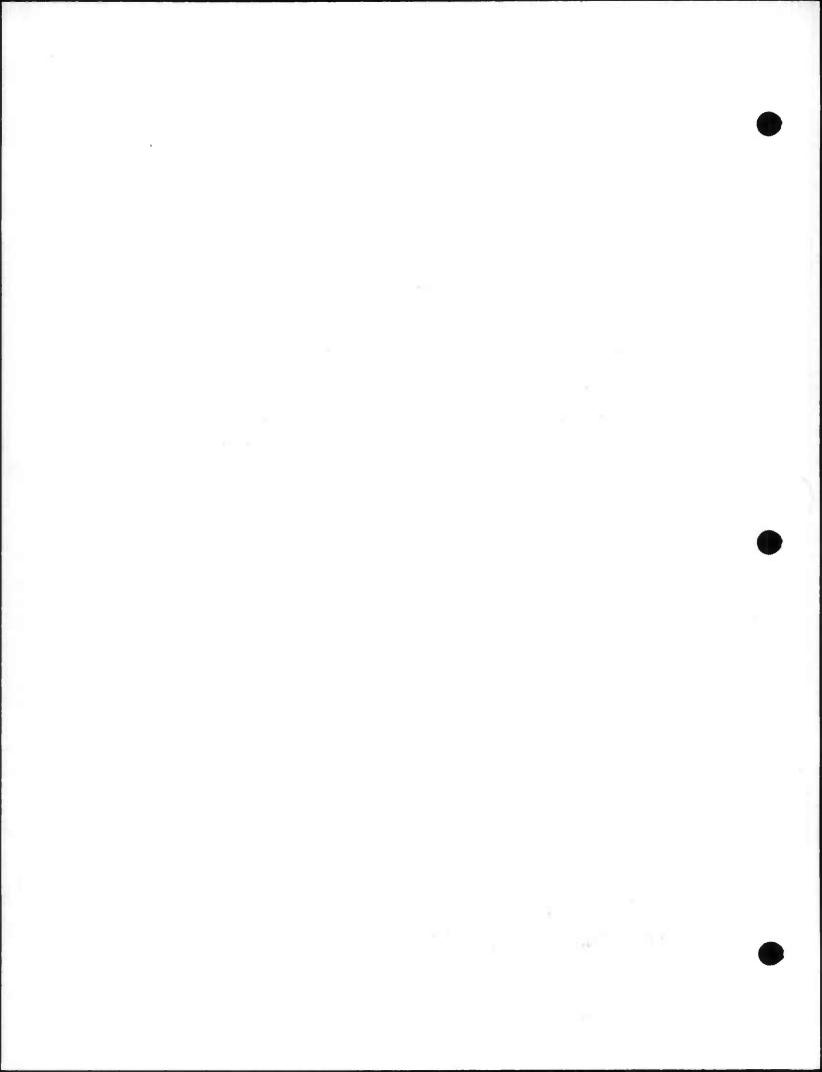
TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the functal director, page 5 should be detached for use as the burial-transit permoval. To hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.
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										95	3	8061
	FOR 1 - STATE REGISTRAR	STATE OF I							MENTAL HYGIEN	ΙE		
			C	ERIIF	ICAI	E OF	DEATH	Н	REG. NO			
	1. DECEDENT'S NAME (First, Middle, Lest) FEARN LO		HARRISON	1					2. DATE OF DEATH MONTH December	~ 11,1	995	3. TIME OF DEATH 10;30 A. M
	4. SOCIAL SECURITY NUMBER 220-28-8478	5. SEX	6. AGE (In yrs. las	st birthday)	IF UNDE	DAYS	IF UNDER 24	HRS. MIN.	7. DATE OF BIRTH (Month, Day, Year) May 30, 19	8. BIRTHPLACE (State or Foreign Country)		
	Sa. FACILITY NAME (If not institution, give					J						sburg, Md.
OR	3372 Old Gamber			96. CIT	Y, TOWN C	Fink			9c. COU	INTY OF DE	Carroll	
5	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNT	~	10c. CITY, TOWN OR LOCATION									
DIRECTOR		rroll				sbur						10d. INSIDE CITY LIMITS? 1 YES 2 NO
FUNERAL	3372 Old Gambe				101	21048	3		10g. CIT		HAT COUNTRY?	
N N	11. MARITAL STATUS	12 WAS DECEDEN	IT EVER IN U.S. AF	MED		W# 6 DEC	ENDENT OF	MODAN	10.0010110.00			
BY FL	1 Never Merried 2 Married 3 Wildowed 4 Divorced		YES 2 X		13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify No. 11 yes, specify Cuban, Maxican, Puarto Rican, stc.) 1 YES 2 NO. Specify:					or No-	Specify.	- American Indian, White, etc.
Q	15. DECEDENT'S EDU	CATION	16a. DE	CEDENT'S	USUAL C	OCCLIPATIO	DN .		16b, KIND OF BU	CINERO (INI	•	WILLE
E	(Specify only highest grad	e completed)	(G	live kind of a	work done	during mo	st of working		100. KIND OF BU	SINE 35/INI	DUSTRY	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) High School 16e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOUSEWIFE 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname)										me		
0	17. FATHER'S NAME (First, Middle, Last)						18. MOTHE	R'S NAI	AE (First, Middle, Maiden	Sumame)		
	10 INFORMANT'S NAME (Total Print)											
Mrs. Deloris F. Iyler 2708 Wildorlyn Dr. Finksburg, Md. 21048 20a. Method of bisposition Date												
									Md .			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY 11824 Reisterstown ELINE FUNERAL HOME Reisterstown, Md.										stown Rd.		
										Md. 21136		
	23. PART I. Enter the diseases, or shock, or haart fallure.	complications the	t caused the de	eth. Do i	not enta	r the mo	de of dying	g, auch	aa cerdiac or reap	ratory ar	reat,	Approximate
	IMMEDIATE CAUSE (Final	A A	ise on each line									Onset and Death
	disease or condition resulting in death)	. Acri	le									
		DUE TO	(OR AS A CONSE	DUENCE O	F):							
동	Sequentially list conditions,	0. HB	2									10 42
ERTIFICATION	if any, leading to immediate	от зиа	(OR AS A CONSE	DUENCE O	F):							
2	CAUSE (Disease or injury	c										
盲	that initiated eventa resulting in dasth) LAST	DUE TO	(OR AS A CONSE	DUENCE O	F):							
CER		d										
	PART II. Other aignificant condition	na contributing to	death but not r	reaulting	In the u	ndariying	cause giv	en in I	Part I. 24s. WAS AN	AUTOPSY	24b.	WERE AUTOPSY FINDINGS
EDICAL									PERFOR			AVAILABLE PRIOR TO COMPLETION OF CAUSE
요					-				1 □ YES 2	NO NO		OF DEATH?
Σ.	DID TOBACCO USE CONT	RIBUTE TO CA	USE OF DEA	TH YE	sП	NO [UNCER	RTAIN	rta			1 TYES 2 ANO
A	25. WAS CASE REFERRED TO MEDICAL			E OF DEAT			OTTOE	NI/AII V		-		
Sic	EXAMINER?	HOSPITAL:	FR/Outpetient 3	□ DOA	OTHE				B Other (Specify)			
PHYSICIAN:	27. MANNER OF DEATH	28a. DATE OF	INJURY	28b. TIM		28c. INJ		denca :	28d. DE\$CRIBE HOW I	NJURY OC	CURED	
	1 Natural 5 Pending	(Month, D	ay, Ybar)	INJ	URY	wo	RK? 'ES 2 - F	NO			OUNLE	
ЭВУ	2 Accident Investigation 3 Suicide 8 Could not be	28a. PLACE O	F INJURY — At ho	me, tarm, s	street, tac	tory, office		_	281. LOCATION (Street I	and Number	r or Rurel Ac	ute Number.
ЕТЕР	4 Homicide	building,	atc. (Specify)						City or Yown, State)			
	29a. CERTIFIER 1 CERTIFYING PHYS	ICIAN: To the best of	my knowledge, de	ath occurre	d at the	time, data	and place, ar	nd due t	to the cause(a) and mar	iner as stat	ted.	
COMPL	orie) 2 MEDICAL EXAMINI											and manner as stated.
m-II	296. SIGNATURE AND TITLE OF CHITTIFIE	H 5					29c. LICENS	SE NUM	BER	29d. DAT	E SIGNED (Month(Day, Year)
0	apri-						DS	-	4.1	>	12/17	185
일 #	TO NAME AND ADDRESS OF DESCRIPTION WHO COMPILETED CAUSE OF DEATH WITH AND ADDRESS OF DESCRIPTION										117	

Finksburg, Md. 21048

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Renzo Ricci M.D. 3125 Baltimore Blvd.

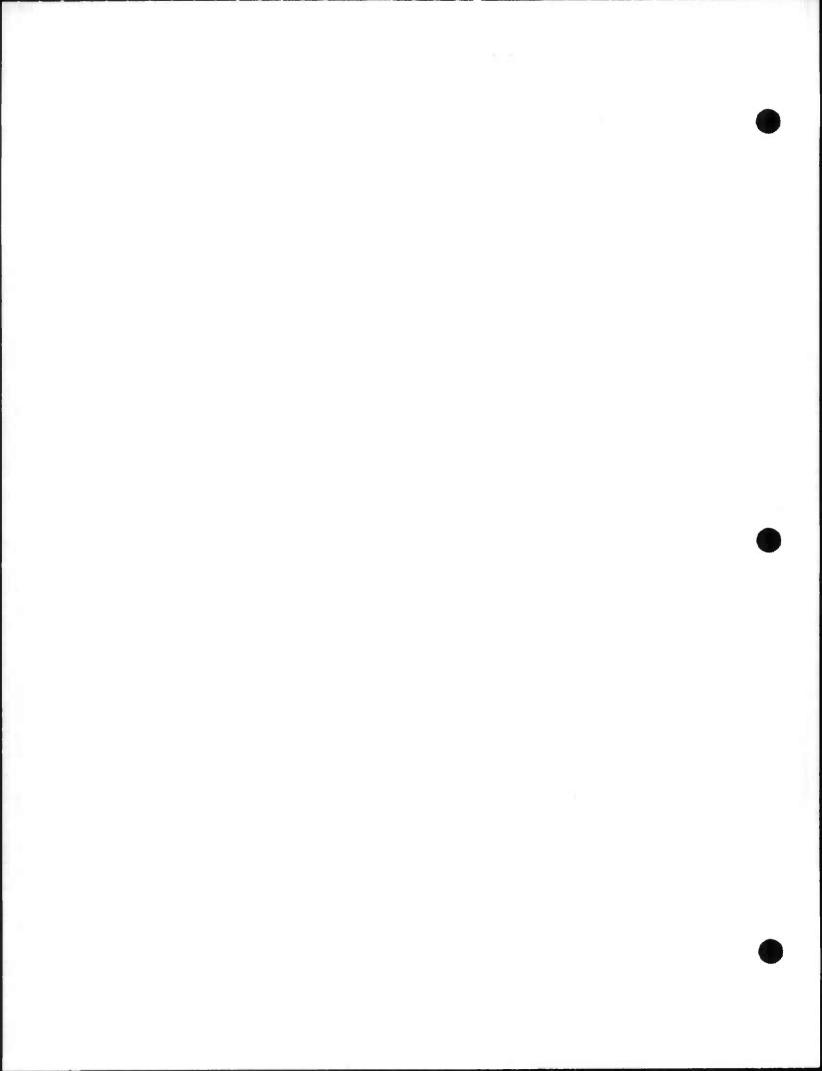
32. REGISTRAR SOIGNATURE



1 - FOR STATE REGISTRAR

)		4. SOCIAL SECURITY NUMBER	evens Holl	1 y 8. AGE (In yrs. ia	st birthday) IF U	ENS HDER I YEAR	IF UNDER 24 MRS.	2. DATE OF MONTH	INDES DA	10 1	991	TIME OF DEATH 1 1 A M ACE (State or Foreign
pi		218-16-7602	1 € M 2 □ F	71	YRS. MONT	HS DAYS	HOURS MIN.	APR I	6, 19)24 N	Mary 1	
i, 2, 3 should	TOR	90. FACILITY NAME (If not institution, give Joseph Richey Hoses December 1				ary, rown o	OR LOCATION OF D	EATH	- 19	9c. COUNT N/A	TY OF DEAT	н
nit. Pages 1	DIRECTOR	Maryland N/A	Υ		10c. CITY, TOV	VN OR LOCA	Baltimoı	re				d. INSIDE CITY LIMITS? YES 2 NO
nsit perr	FUNERAL	820 North Eutaw S	treet			101	21201				en of what	T COUNTRY?
r attending physician. use as the bunal-transit permit. Pages 1,	B⊀	11. MARITAL STATUS 1. Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT FORCES? 1 [IF YES, GIVE WA	YES 2X	AMED NO	If yes, sp	CENDENT OF HISPA ecity Cuben, Mexico 2 NO Specific	en, Puerlo Ric			14. RACE — Black, W	American Indian, Inita, atc.
or attend	ETED	15. DECEDENT'S EDU (Specify only highest grade	e completed)	(C)	ECEDENT'S USUA live kind of work do Do NOT use retire	one durina ma		16b. K	NO OF BUS	SINESS/INDU		
the hospital o detached for once.	E COMPL	Elementary/Secondary (0-12)	College (1-4 or 5+)		borer			Pr	cint S	Shop		
क दि		17. FATHER'S NAME (First, Middle, Lest) Frank Holly					18. MOTNER'S NA	ME (First, Mid Minnie				
retained to 5 should notified	TO B	19a. INFORMANT'S NAME (Type/Print) Mary Ann Kaiser					and Number or Rural	Route Number,	City or Town	n, State, Zip C		
e 6 may be ector, page t		20a. METNOD OF DISPOSITION 1	noval from State	20b. PLACE	AND DATE OF DIS	POSITION (Na		DATE 11/95	20c. LOC	, MD 2 cation — ci timore	lty or Town,	
death. Pag funeral dir sxaminer		21. SIGNATURE OF FUNERAL SERVICE LI	CENSEE Dawn F	F. McDor	nald C	remat	no ADDRESS OF FA	ety o	f Mar	yland	, Inc	
executed within 24 and completely fill to burial, cremation matic event, the	CERTIFICATION	23. PART i. Enter the diseases, or shock, or heart failure. IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury	a. DUE TO (e on each line	OV COLORO	iter the mo	de of dying, auc					Approximata Interval Between Onset and Death
death certifical attending physical Hygiene intal Hygiene intal Hygiene intal hygiene int.	SERTIF	that initiated events resulting in death) LAST	,	IN OUNC		UNG	ĵ					15 mos.
vires that the signed by the Health and Me ws any Inju	MEDICAL (PART II. Other eignificant condition		.					PERFORI	MEO?	COL	RE AUTOPSY FINDINGS ALLABLE PRIOR TO MPLETION OF CAUSE DEATH? YES 2 NO
		DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL	RIBUTE TO CAU		TH YES		UNCERTAI	N D				
CIAN: The crifficate he State C	PHYSICIAN	EXAMINER? 1 YES 2 NO	HOSPITAL:		OTH	ER:	e 5 🗆 Residence	6 Donner (S	ipecity) (H05)	1100	,
NG PHYSIC fter this ce eath with te marked,	ву Рн	27. MANNER OF DEATH 1 Natural 5 Pending 2 Accident Investigation	28a. DATE OF III (Month, Day,		28b. TIME OF INJURY		URY AT PRK? YES 2 NO	28d, DESCR	IBE NOW IN	NURY OOKU	RED	
RECTOR: After de m 28 ls r	ETED I	3 Suicide 8 Could not be determined	28e. PLACE OF building, et	INJURY — At ho tc. (Specify)	eme, farm, street,	tactory, offic	•	281. LOCATI City or 1	ON (Street ar Town, State)	nd Number or	Rural Route	Number,
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law TO THE FUNERAL DIRECTOR: After this certificate has be filed within 72 hours after death with the State Dept. IMPORTANT: If Item 28 is marked, or Item 23	COMPLI	29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINE	ER: On the beals of axa									d manner as stated.
TO THE HOSPI TO THE FUNER be filed within	TO BE C	296. SIGNATURE AND TITLE OF CENTIFIE	Brun	w			29c. LICENSE NUI	WBER			SIGNED (Moi	onth, Day, Year)
	F	30. NAME AND ADDRESS OF PERSON WH	FWIN M	10 8	28N.	Eug	law 54.	VSa	140	M.	12	1201
		DEC 1 5 1995	32 REGISTRAN	's SIGNATURE	lall							
•												OHMH-16 Rev 1/8

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.



DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE MORPITAL OR ATTENDING DEVOLUTION. The law remines that the death certificate has executed that the death certificate has executed to the control of t	Committee the sectional by the free free section of
TO THE HOOF THE CITY OF THE PROPERTY THE WAY TO COME THE CONTRACTOR OF CHARLES OF CHARLES	the of they be retained by the hospital of attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the	s has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the hursal-transit narmit. Pages 1.2 secured
be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to bunial, cremation, or removal.	[B]
IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	examiner must be notified at once.
TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION	TO BE COMPLETED BY FUNERAL DIRECTOR

											9!	5 3	8069
	FOR 1 - STATE REGISTRAR	STATE OF MARY	LAND /	DEPART	MENT	OF H	EALTH	AND I	MENTA				
	1. DECEDENT'S NAME (First, Middle, Last)		- OL	KIIFIC	AIL	OF	DEAL	П		REG. NO			3. TIME OF DEATN
COMPLETED BY FUNERAL DIRECTOR	James Imes 4. SOCIAL SECURITY NUMBER									ember	12,	1995	8:20 A M
	218-09-7647	1 XXM 2 □ F	00					24 HRS. MIN.	JAN. 2, 1912				LTIMORE, MD
	98. FACILITY NAME (If not institution, give street and number) 8 Salem Court RESIDENCE OF DECEDENT						or location of Death It imore 9c. COUNTY OF DEATH n/a						
	MARYLAND 106. COUNTY n/a				10c. CITY, TOWN OR LOCATION BALTIMORE							10d. INSIDE CITY UMITS? 1 VES 2 NO	
	1720 MC KEAN			101. ZIP CODE 10g. CITIZE UNIT						STATES			
	11. MARITAL STATUS 1 Never Married 2 Married 3 Wildowed 4 Diverced	IN U.S. ARA 2 DATES NK.	MED	ED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specific version of the second of the secon					7 (Specify Ye	y Yes or No— 14. RACE — American Indian, Black, White, etc. Specify: black			
	15. DECEDENT'S EDUCA (Specify only highest grade or Elementary/Secondary (0-12) 9 th	TION 16e. DECEDENT'S USUAL OCCI (Give kind of work done duri life. Do NOT use retired.) LABORER				ring mo	N st of working	9	16b.			HINERY	
BE CON	17. FATNER'S NAME (First, Middle, Last) JOHN HENRY IMES						18. MOTH	er's nai AME I	AME (First, Middle, Melden Surneme) ILA MATTHEWS				
TO B	199. INFORMANT'S NAME (Type/Print) PLEASANT IMES 190. MAILING AGORESS (Str. 1720 MC)					Street e	KEAN AVENUE, BALTIMORE, MD 21217						
	20e. METHOD OF DISPOSITION X												
	sachag hay neg x has								TH AVENUE				
EDICAL CERTIFICATION	IMMEDIATE CAUSE (Final disease or condition Metastatic Prostate Cancer									Approximats Interval Between Onset and Death 24 Months			
	Sequentially list conditions, If any, leading to immediate cause. Enter UNDERLYING												
	CAUSE (Disease or Injury that Initiated events resulting in death) LAST d. DUE TO (OR AS A CONSEQUENCE OF):												
	PERFORMED? 1 Tyes 2 No									WERE AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?			
Z Z	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN									1 Tes 2 No			
PHYSICIAN: MEDICAL	25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL: OTHER:												
	1 YES 2 NO 1 27. MANNER OF OEATN 1 Natural 5 Pending	1 Inpetient 2 ER/Outpetient 3 DOA 4 Nursing H-					ome 5 ☐ Residence 6 ☐ Other (Specify) AJURY AT 28d. DE\$CRIBE NOW INJURY OCCURED ORK?						
TED BY	2 Accident Investigation 3 Suicide 6 Could not be 28s. PLACE OF INJURY — At home, tarm, street, factory, office 28s. LCC							f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
COMPLETED	29a. CERTIFIER (Check only one) CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated. MEDICAL EXAMINER: On the best of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and menner as stated.												
BE	29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Mon D 2 41 49 12/12/6												
유	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF O	EATN //TEM	27) / Tono (Driv	-41							1	110

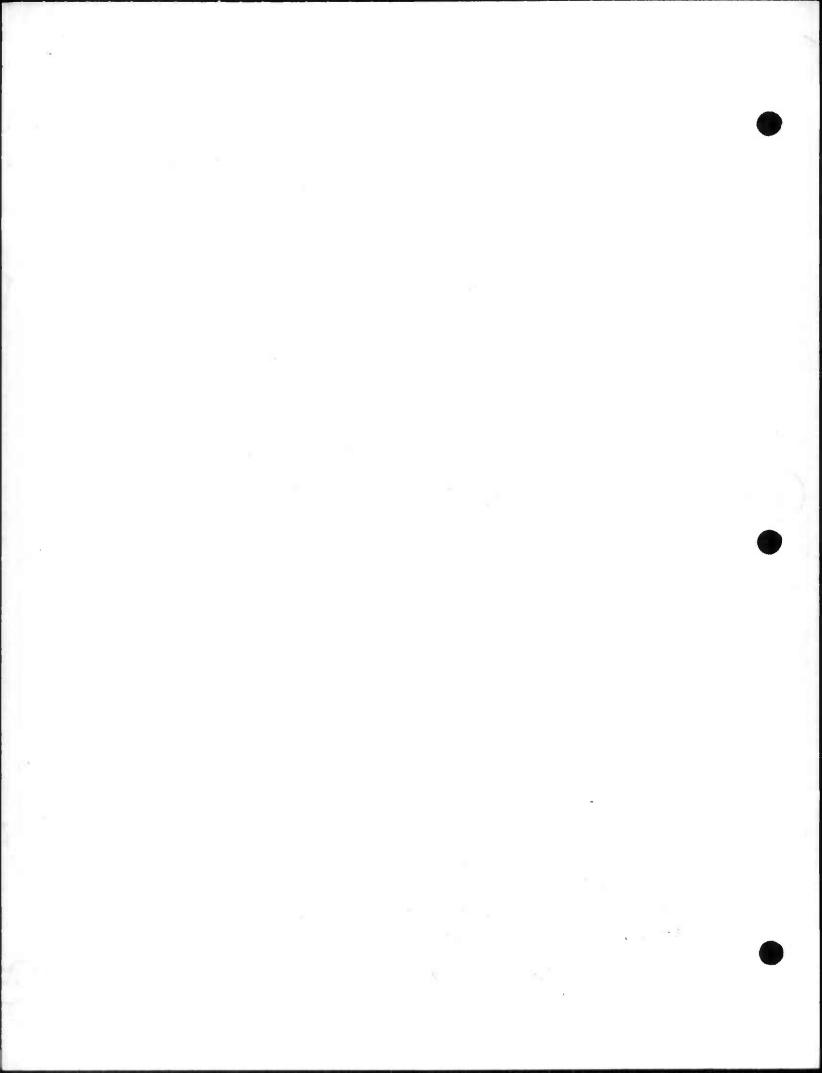
COMPLETED CAUSE OF OEATN (ITEM 27) (Type, Print)

Dorothy Snow, M.D., 10 N. Greene St., Baltimore, MD

31. DATE FILED (Month, Day, Vear)

DEC 1 5 1995

32. REGISTRAR'S SIGNATURE



DHMH-16 Rev 1/89

a may be retained by the hospital or attending physician. MORE, MARYLAND 21215-0020 OR ATTENDING PHYSICIAN; The law requires that the death certificate be executed within DIVISION OF VITAL RECORDS, P.O. BOX 68760,

HOSPITAL

Pages 1, 2, 3 should

permit.

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use as the

page 5 should be detached for

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 -CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH 625 TYRONE 1 WITH A IA CKSON 7. DATE OF BIRTH (Month, Day, Year) 6. AGE (in yrs. last birthday) 4. SOCIAL SECURITY NUMBER 5. SEX BIRTHPLACE (Stafe or Foreign Country) IF UNDER 1 YEAR | IF UNDER 24 HRS. 8-94-9909 MONTHS DAYS 1 M 2 - F HOURS 32 YRS. WASH. D.C 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH HYATISVILLE P.6. HUTH. CARE CENTER DIRECTOR HYATTSVILLE RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10d. INSIDE CITY LIMITS? D.C. n/a Washington 1 YES 27 NO FUNERAL 10e, STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 2375 11th St. NW apt. 32 20001 USA 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 KIND 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No—If yea, specify Cuban, Mexican, Puerto Rican, etc.)
1 YES 2 3 60 Specify: 11. MARITAL STATUS 14. RACE — American Indian, Black, White, etc. 1 Nover Married 2 Married IF YES, GIVE WAR OR DATES BY 3 Widowed 4 Divorced Black COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade comple 16a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY (Give kind of work done during most of working life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) GED Waiter = Private Restauran 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Ħ Tyrone A. JAckson, Sr. Emily Robinson notified 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or " Washington, D.C. Emily Jackson 2375 11th St. NW apt. Balto . / 20001 32 9 20a. METHOD OF DISPOSITION
1 State 2 □ Cremation 3 □ Removal from State 20b. PLACE AND DATE OF DISPOSITION (Nama of 20c. LOCATION - City or Town, Stata must Glenwood Cemetery 4 Donation 5 Other (Specify) Washington, D.c 21. SIGNATORE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY James A. Morton & Sons Funeral Home 457 Laurens St. Balto., MD medical Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, the attending physician and completely filled in by Mental Hygiene prior to burial, cremation, or remo-Approximate Interval Between ock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final Onset and Death 8 disease or condition event, resulting in death) traumatic CERTIFICATION Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF). or other DUE TO (OR AS A CONSEQUENCE OF): resulting in death) LAST Injury. MEDICAL ath but not resulting in th underlying cause given in Part I. 24s. WAS AN AUTOPEY 24h. WERE AUTOPSY FINDINGS Health and I MA me shall AVAILABLE PRIOR TO shows any COMPLETION OF CAUSE 1 THE 2 SHO OF DEATHS has been a Dept. of H 1 TYES 2 NO PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL 36. PLACE OF DEATH (Check only one this certificate in with the State I llem OTHER: 1 | YES 2 040 1 Inpetient 2 ER/Outpetient 3 DOA 2 6 me S 🗆 Residence S 🗆 Other (Specify) 27. MANUER OF DEATH 28s. DATE OF INJUSTY (Month, Day, Year) 28b. TIME OF 26c. INJURY AT WORK? 284 DESCRIBE HOW INJURY OCCURED marked. 1 Menural 5 Pending 1 YES 2 NO BY After 2 Accident 26e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. LOCATION (Street and Number or Flurel Route Number City or Reen, State) 劫 DIRECTOR: J COMPLETED 28 Ihem 1 CERTIFYING PHYSICIAN: pest of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. FLINERAL within 72 i 2 MEDICAL EXAMI IMPORTANT URE AND TITLE OF C LICENSE WINDER 불불물 BE Dec. 12 244 0 ewis GREEN De 32 REGISTRAR'S SIGNATURE 31. DATE FILED (Month, Day, Year) DEC 1

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DIVISION OF VITAL RECORDS, P.O. BOX 6876

and director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should Page 6 may be retained by the hospital or attending physician. TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hospital and provide a may be intrinsed by the attending physician and completely filled in the first lunear director, and is account the considerable of the state begins of Health and Mental Hygiene prior to burial, cremation, or minoral examinar must be notified at once, IMPORTANT: If Hem 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical assuminar must be notified at once.

IMORE, MARYLAND 21215-0020

	1 - STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.										
	1. DECEDENT'S NAME (First, Middle, Last)			0,111		2. DATE O	E DEATH			. TIME OF OEATH	
,	Raymond Earl Jeffers						.13,9	[*] 995 [*]	EAR	3:30p M	
		The state of the s	rs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF	FBIRTH	8.	BIRTHP	LACE (State or Foreign	
	579-54-7039 1 M 2 - F 52 YRS. MONTHS DAYS HOURS MIN. Aug.						5,19	1943 Washington,			
~	Sa. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEA										
DIRECTOR	Anne Arundel Medical Center Annapolis Anne Arundel										
E.	10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. MD Anne Arundel Churchton 10d.									Od. INSIDE CITY	
										DÖYES 2 □ NO	
RA	100. STREET AND NUMBER 1230 Garrett Avenue 2073							USA	OF WH	AT COUNTRY?	
FUNERAL	11. MARITAL STATUS	10 110 0									
	1 Never Married 2 Married	If yes,	ECENDENT OF HISPAN specify Cuban, Maxica	in, Puarto Ak		or No — 14	Black,	- American Indian, White, etc.			
B	1 Never Married 2 Married 3 Wildowed 4 Divorced FORCES? 1 YES 2 NO If yes, specify Cuban, Maxican, Puarto Rican, etc.) Black, White, etc. Specify: White								White		
COMPLETED	15. DECEDENT'S EDUCAT (Specify only highest grade co.	TION 18	a. DECEDENT'S L	USUAL OCCUPAT	TION	16b. F	UND OF BUS	INESS/INDUS	TRY		
	Elementary/Secondary (0-12)	College (1-4 or 5+)		rork done during restired.)	nost or working	Electronics					
MP	12 Technician Electro								CS		
8	17. FATHER'S NAME (First, Middle, Last) Earl Lindsey Je	effers			Floren	ME (First, Mid	ddle, Maiden Mav I	Surname)			
BE	19a. INFORMANT'S NAME (Type/Print)		T 401 14411 1110								
2	Mary Ellen Jeff	fers	1230	Garre	and Number or Rural	ue, (Churc	hton	, M	D 20733	
	Mary Ellen Jeffers 1230 Garrett Avenue, Churchton, MD 20733 20a. METHOD OF DISPOSITION 20b. PLACE AND OATE OF DISPOSITION/Nome of DATE 20c. LOCATION — City or Town, State										
	1 Seurial 2 Cremation 3 Remova	al from State cemeter	ry, cremetory or oth	ld Cen	eterv	1				le,MD	
	21. SHINATURE AN FUMERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY										
- 1	Hardesty Funeral Home, P.A. 12 Ridgely Ave. Annapolis, MD 21401										
-	23. PART I. Enter the disphase, or cor	molications that caused th	ne deeth. Do no							MD 21401	
	shock, or heal's failure. Lis	at only one ceuse on each	line.	Of aine, nee	iode or dynig, eac	II as varun	C OT 100ps	ratory arres		interval Between Onset and Death	
	disease or condition Ventricular tacluscarditA Y2 Hour										
	disease or condition resulting in deeth) e. Ventricular tachycardia b. Coronary artery disease Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): CORONARY ARTERY DISEASE DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):										
Z	Sequentially list conditions, Coronary artery dislate 154rs										
NT I	oue to (or as a consequence of): If any, leading to immediate cause. Enter UNDERLYING										
5	CAUSE (Disease or Injury C. CA										
CERTIFICATION	that initiated eventa resulting in death) LAST										
S	d										
AL	PART ii. Other algnificant conditions contributing to death but not resulting in the underlying ceuse given in Part i. 24a. WAS AN / PERFORI										
DIC	1 U YES 2 NO									COMPLETION OF CAUSE OF DEATH?	
ME	1									YES 2 NO	
PHYSICIAN: MEDIC	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN										
2	25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL: OTHER:										
IYS	1 YES 2 NO 1	28a. DATE OF INJURY			ome 5 Raaldence						
	1 Natural 5 Pending	(Month, Day, Year)	28b. TIME	URY V	VORK?	28d. DEŞC	RIBE HOW II	NJURY OCCUP	RED		
BY	Accident Investigation 3 Suicide Could not be	28a. PLACE OF INJURY —		281. LOCATION (Street and Number or Rural Route Number,							
윤	3 Suicide 8 Could not be detarmined 28a. PLACE OF INJURY — All home, farm, street, factory, office building, aic. (Specify) 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)									ore remove,	
COMPLET	29s. CERTIFIER 19 CERTIFYING PHYSICIAN: To the heat of my knowledge, death occurred at the time, date and place, and the to the association of the limit of the second date to the association of the limit of the second date to the association of the limit of the second date to th										
MP	(Check only one) 2 MEDICAL EXAMINER: On the best of exemination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(a) and manner as stated. (MEDICAL EXAMINER: On the best of exemination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(a) and manner as stated.										
	29b. SIGNATURE AND TITLE OF CERTIFIER						1	29d. DATE S			
8								► 1.2	- /	Month, Day, Year)	
임	36. NAME AND ADDRESS OF PERSON WHO COMPLETED DAUSE OF DEATH (ITEM 27) (Type, Print)										
	Susan H. Kriger, MD D44838 > 12-14-95 SUSAN KRIEGER, MD OWENSVIlle Medical CTR										
	DEC 1 5 1995 Jalia Pala Pala Pala Pala Pala Pala Pala										

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and dearn. Page 6 may be retained by the hospital or attent	attending physician and completely filled in by the funeral director, page 5 should be detached for use as	
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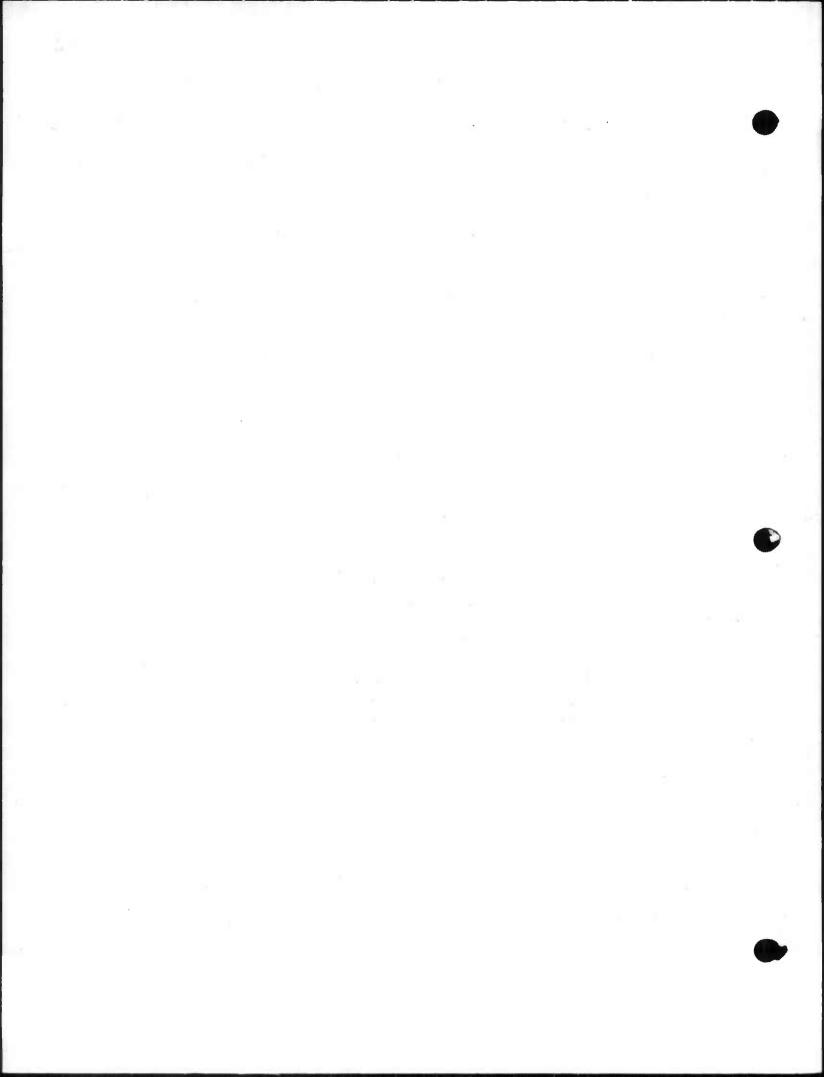
DIVISION OF VITAL RECORDS, P.O. BOX 68760,

ding physician. s the burial-transit permit. Pages 1, 2, 3 should TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with the completely filled in by the tuneral director, page 5 should be detached to THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If them 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	1 - FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.								
6.0	1. DECEDENT'S NAME (First, Middle, Last) DO NA LD	KPS		2.	DATE OF DEATH DAY 2	2 geas 3. TIME OF DEATH PM			
R	4. SOCIAL SECURITY NUMBER 5. SEX 212-36-6571 1 ☑ M	6. AGE (In yrs. last i	VRS. IF UNDER 1 YEAR DAYS	HOURS MIN.	DATE OF BIRTH (Month, Day, Year)	8. BIRTHPLACE (State or Foreign Country) 38 Maryland			
	90. FACILITY NAME (If not institution, give street and in Bayview Hospita	*		R LOCATION OF DEATH		COUNTY OF GEATH			
DIRECTOR	RESIDENCE OF DECEDENT 100. STATE 10b. COUNTY								
DIRE	= -	imore	10c. CITY, TOWN OR LOCA	Essex		10d. INSIDE CITY LIMITS? 1 YES 2 NO			
3AL	10e. STREET AND NUMBER	_	10	. ZIP CODE		g. CITIZEN OF WHAT COUNTRY?			
FUNERAL	299 Townsend Roa	A.C. S DECEDENT EVER IN U.S. ARM	ED 13. WAS DE	2122	PRIGIN7 (Specify Yes or N	USA to— 14. RACE — American Indian,			
B⊀	1 Never Merried 2 Merried FOR	RCES? 1 TYES 2 THO ES, GIVE WAR OR DATES	If yes, sp	ecify Cuben, Mexicen, Pt 2 NO Specify	uerto Rican, atc.)	Black, White, etc. Specify: White			
COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed Elementary/Secondery (0-12) College	d) (Give	EDENT'S USUAL OCCUPATI e kind of work done during m Do NOT use retired.)	ON st of working	16b. KIND OF BUSINES	OF BUSINESS/INDUSTRY			
MP	10th. 17. FATHER'S NAME (First, Middle, Lest)	Ba	rtender		Bar				
	Emil Krs Jr.				First, Middle, Maiden Surni Elyn Hugh				
TO BE	19e. INFORMANT'S NAME (Type/Print)		MAILING ADDRESS (Street	nd Number or Rural Route	Number, City or Town, Ste	ate, Zip Code)			
-	Kerri Rose Smith		2 Minkler						
	20b. PLACE AND DATE OF DISPOSITION 1X Burisi 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other piece) Bohemian National 12/16/95 Baltimore MD.								
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY								
Connelly Funeral Home of Ess 300 Mace Ave. Baltimore Md. 23. PART I. Enter the diseases, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, A									
	shock, or heart feffure. List only IMMEDIATE CAUSE (Final	y one cause on each line.	2.	1	a cardiac or reapireto	Approximata interval Between Onset and Death			
CERTIFICATION	Sequentially list conditions, if any leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events								
EH	resulting in death) LAST d. Waseles mellitus								
PHYSICIAN: MEDICAL (PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Silateral bolow knee amountations 1 yes 2 No 248. WAS AN AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? YES 2 NO 1 yes 2 NO 1								
SiC!/		PITAL:	OTHER:	ACE OF DEATH (Check of					
	27. MANNER OF OEATH 28.	1 Inpatient 2 ER/Outpetient 3 DOA Norsing Home 5 Residence 6 Other (Specify) 28e. DATE OF INJURY (Month, Dey, Year) 28b. TIME OF INJURY AT WORK? WORK							
TED BY	- Accident	28e. PLACE OF INJURY — At home, ferm, street, factory, office building, etc. (Specify) 28f. LOCATION (Street and Number or Rural Route Number, Cliv. or Feer, State)							
COMPLET	29e. CERTIFIER (Check only one) 2 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) end menner as stated. MEDICAL EXAMINER: On the basic of examination end/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(e) end menner se stated.								
TO BE C	296. SIGNATURE AND TITLE OF CERTIFIER 30. NAME AND ADDRESS OF PERSON WHO COMPL	32		D419	290	12 13 95			
	Bello AD 21224								
	DEC 1 5 1995	REGISTRAR SIGNATURE							

DHMH-16 Rev 1/89



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38073 95 FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO 2. DATE OF DEATH DAY 1. DECEDENT'S NAME (First Middle Last) 3. TIME OF DEATH MARVIN KING 9.20 PM DECEMBER 13 1995 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. lest birthday) IF UNDER 1 YEAR 7. DATE OF BIFTH 8. BIRTHPLACE (State or Foreign IF UNDER 24 HRS. 214-64-4209 40 YRS. DAYS JUN"18 1955 MARYLAND 1 XXM 2 | F 9e. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH n/a DIRECTOR UNION MEMORIAL HOSPITAL BALTIMORE CITY 10a. STATE 10b. COUNTY 10c, CITY, TOWN OR LOCATION 10d. INSIDE CITY MARYL AND YES 2 NO n/a BALTIMORE 10a. STREET AND NUMBER FUNERAL 101, ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 2702 TIVOLY **AVENUE** 21218 UNITED STATES 11. MARITAL STATUS

Never Married 2 Merried 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ÛNO IF YES, OIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No-if yee, specify Cuben, Mexican, Puerto Rican, etc.)

1 YES 2 NO Specify: 14. RACE - American Indian, Black, White, stc. BY Specify: BLACK 3 Widowed 4 Divorced COMPLETED 15. DECEDENT'S EDUCATION 16e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY condary (0-12) College (1-4 or 6+) 10 LABORER CONSTRUCTION 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Meiden Sumame) WILLIE KING VIOLA MITCHELL BE 19a, INFORMANT'S NAME (Type/Print) Number or Rural Route Number, City or Yown, St AVENUE, BALTIMORE, MD State, Zip Code) D 21218 2 2702 VIOLA KING TIVOLY 20s. METHOD OF DISPOSITION
1 Surial 2 Cremetion 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State COBOAY TO MORE TO PICE METERY 12 - 18BALTIMORE, MD 4 Donation 6 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY WM. C. MARCH FH.-1101 E. NORTH **AVENUE** 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximata shock, or heart fallura. List only one cause on each line. interval Batween IMMEDIATE CAUSE (Final Onset and Death SHOCK. SEPTIC disease or condition resulting in death) 24HRS DUE TO (OR AS A CONSEQUENCE OF) 10 MRS RESPIRATORY FAILURE CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF) if any, leading to immediate cause. Enter UNDERLYING 10 HRS RENAL FAILURE CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 3 DAYS BACTERIAL ENDOCARDITIS PART ii. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY PERFORMED? MEDICAL 24b. WERE AUTOP6Y FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? IVDA. 1 | YES 2 - NO 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 YES 2 NO Inpatient 2 - ER/Outpatient 3 - DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 26c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 Natural
2 Accident 1 YES 2 NO BY Investigation 28e. PLACE OF INJURY — At home, farm, street, factory, office building, stc. (Specify) 3 Sulcide 8 Could not be determined 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 4 Homicide 29e. CERTIFIER (Check only Line (Check only CERTIFYINO PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) end menner ee stated. 2 MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) end manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER

29c. LICENSE NUMBER

UNION MEMBER MOSPITAL, 2018, UNIVPEWY, BALTIMERE, MD 21218

AT 2438946

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

32. REOISTRAR'S SIGNATURE

and

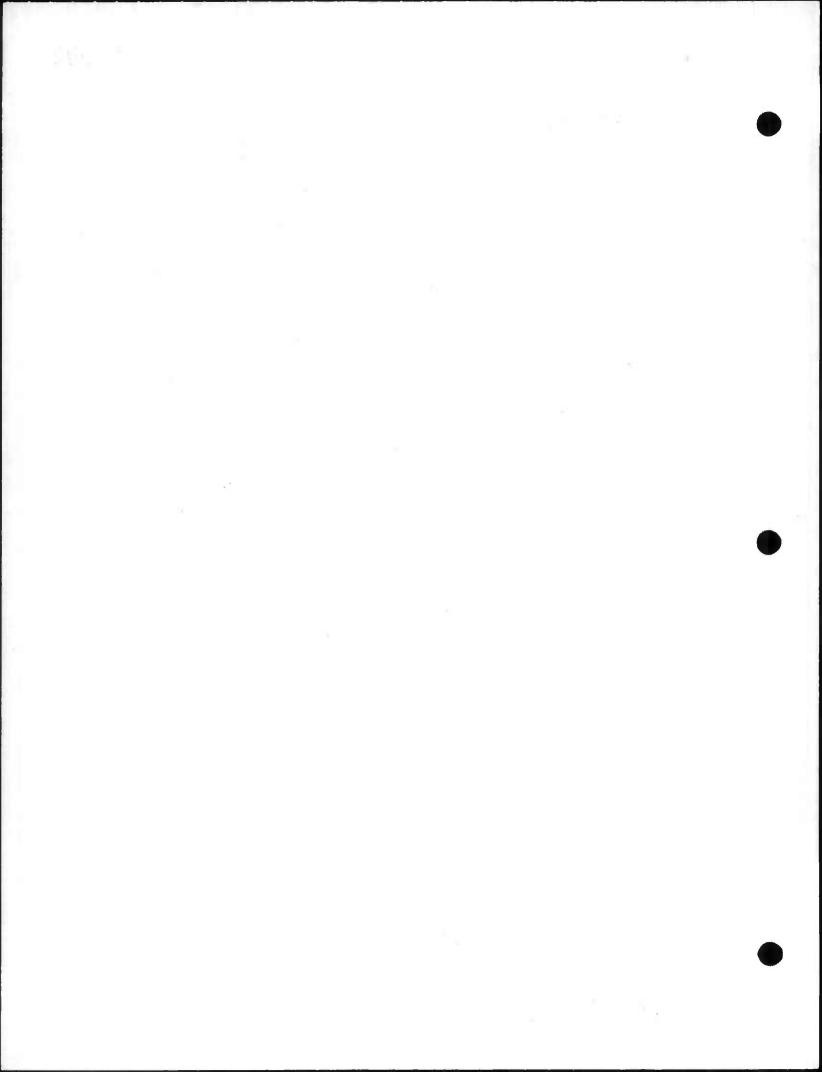
DEC 1 5 1995

R. PAUL, 31. DATE FILED (Month, Day, Year)

DHMH-16 Rev 1/89

29d. DATE SIGNED (Month, Day, Year)

DEC, 13, 1995



TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with the found that the found of the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely liked in the fluctuary page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be flied within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremitally recommended at the properties of them 28 is marked, or lifem 23 shows any injury, or other traumatic event. The medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, P.O. BOX 68760

BALTIMORE, MARYLAND 21215-0020

DEC 1 5 1995

32 REGISTRAR'S CONSUME

	FOR STATE REGISTRAR		STATE OF M	ARYLAND /	DEPAR	TMENT O	F HEALTH	AND M	ENTAL HYGIEN			
100	1. DECEDENT'S NAME (First,	Middle, Last)	kida	ler					2. DATE OF DEATH MONTY 2		YEAR	3. TIME OF DEATH
	4. SOCIAL SECURITY NUMB 226-24-4	- 0	5. SEX 1 M 2 F	6. AGE (In yrs. les	t birthday) YRS.	IF UNDER 1 YE		R 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)		BIRTH Countr	PLACE (State or Foreign A)
TOR	POSIDENCE OF DEC	a Ple	treet end number)	v 40th	84	96. CITY, TO	NN OR LOCAT	TON OF DEA	TH .	9c. COUNT	Y OF D	EATH
DIRECTOR	100. STATE	10b. COUNT			-	Y, TOWN OR L	WN OR LOCATION 10d, INS.					10d. INSIDE CITY
	Maryland	Balt	imore Cit	imore City Baltimore							1 X YES 2 - NO	
FUNERAL	10e. STREET AND NUMBER	Oh					10f. ZIP COI			WHAT COUNTRY?		
I S	830 W. 40th	Stree	12. WAS DECEDENT	EVER IN U.S. AR	MED	13. WAS	2121 DECENDENT		C ORIGIN? (Specify Ye		JSA 4. RACE	- American Indian,
BY	1 Never Married 2 S		FORCES? 1 [IF YES, GIVE WA		ÑO .		YES ZXXNO	fy Cuben, Mexican, Puerto Rican, etc.) Black, White, etc. YNO Specify				
ETED	15. DEC (Specify only	EDENT'S EDU highest grade	CATION completed)	(G	live kind of	USUAL OCCU	PATION g most of work	ing	16b. KIND OF BU	SINESS/INDU	STRY	
PE	Elementary/Secondary (0	-12)	College (1-4 or 5+)	College (1-4 or 5+) 4 Homemaker				Otim	Home			
COMPL	17. FATHER'S NAME (First, M.	iddle, Lest)	 		Cille	laker	18. MO	THER'S NAM	E (First, Middle, Melder			
BE	John		t Cheape	7						Minor		
2	190. INFORMANT'S NAME (7) Emily K.	i/pe/Print) Dav							oute Number, City or Tov			
	ROUTE 1 BOX 253 Greenville, Virginia 24440 200_METHOD OF DISPOSITION DATE 200_ LOCATION — City or Town, State											
	4 Donation 5 Other	n 3 ⊟ Rem (Specify)	oven from State	Rive		ther place) ew Ceme	eterv		12/13 Cha			
	21. SIGNATURE OF FUNERA	L service de	ENGLEE JONE				rgee-	ESS OF FACI	LITY			timore, MD
	23. PART I. Enter the diseases, or complications that ceused the desth. Do not enter the mode of dying, such as cardiec or reepiratory arrest, shock, or heart failure List only one ceuse on each line.											
	shock, or heart failure/List only one ceuse on each line. IMMEDIATE CAUSE (Finel									Onset and Daath		
	disesse or condition resulting in death)	+		OR AS A CONSE			mor	N 1,7				8 days
			DOE 10 (OH AS A CONSE	OUENCE U	7):						
CERTIFICATION	Sequentially list conditi if sny, lesding to immed	diete	DUE TO (OR AS A CONSE	OUENCE O	F):						
2	cause. Enter UNDERLYi CAUSE (Disesse or Inju		c.	OR AS A CONSE	OHENCE O	D.						
H	that initisted events resulting in deeth) LAS	т 🌓	4	OH AS A CONSE	OVENCE O	r).						i
	PART II. Other eignifica	nt condition	e contribution to	leath but not .	o a sièla a	le the residen	hutan anna	alona ta B			L	
CAL	Bullous	Pen	0490,0	au but not i	054	Cu poi	was S	given in P	PERFO	RMED?	246.	WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE
MEDIC	Demen	7			A-S	CVI)		1 YES :	NO		OF DEATH?
ž	DID TOBACCO	USE (CONTRIBUTE	TO CAUS	SE OF	DEATH	YES [] NO				
PHYSICIAN:	25. WAS CASE REFERRED TO EXAMINER?	MEDICAL	HOSPITAL:			OTHER:	6. PLACE OF	DEATH (Chec	k only one)			
14S	1 TYES 2 NO		1 Inpetient 2 I		DDA 28b. TIN	4 Nursing	Home 5 F		Other (Specify)	nuting con	1000	
	1 Natural 5	Pending	(Month, Day		IN.	JURY	WORK?		280. DEŞCHIBE NOW	INJURY OCCU	MED	
TED BY	2 Accident Investigation 3 Suicide 8 Could not be determined 28e. PLACE OF INJURY — At home, farm, street, fectory, office building, etc. (Specify)							281. LOCATION (Street and Number or Rural Route Number, City or Town, State)				
PLET	29e. CERTIFIER (Check only	IFYING PHYS	CIAN: To the best of n	ny knowledge, de	ath occurr	ed at the time,	date end plac	e, end due to	o the cause(s) end me	nner es state	1.	
COMPL	(Check only one) 2 MEDICAL EXAMINER: On the basic of examination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) end menner as stated, one)								end manner ee stated.			
BE C	29b. SIGNATURE AND TITLE	OF CERTIFIE	R	29c. LICENSE NUM				ENSE NUME	SE NUMBER 29d. DATE SIGNED (Month, Day, Year)			
10	30. NAME AND ADDRESS OF	PERSON WIL	O COMPLETED CAUSE	OE DEATH AVE	M 27) (5:-	Defeat		3+1:	کک	1	2/	8/95
	Dunna	L.	Dew	M.D	m 21) (1yps	7600	05/	er D	rive #2	ca 1	2,1	FUCICAN +

1995

3. TIME OF DEATN

2. DATE OF DEATH DAY 14,

FOR STATE REGISTRAR

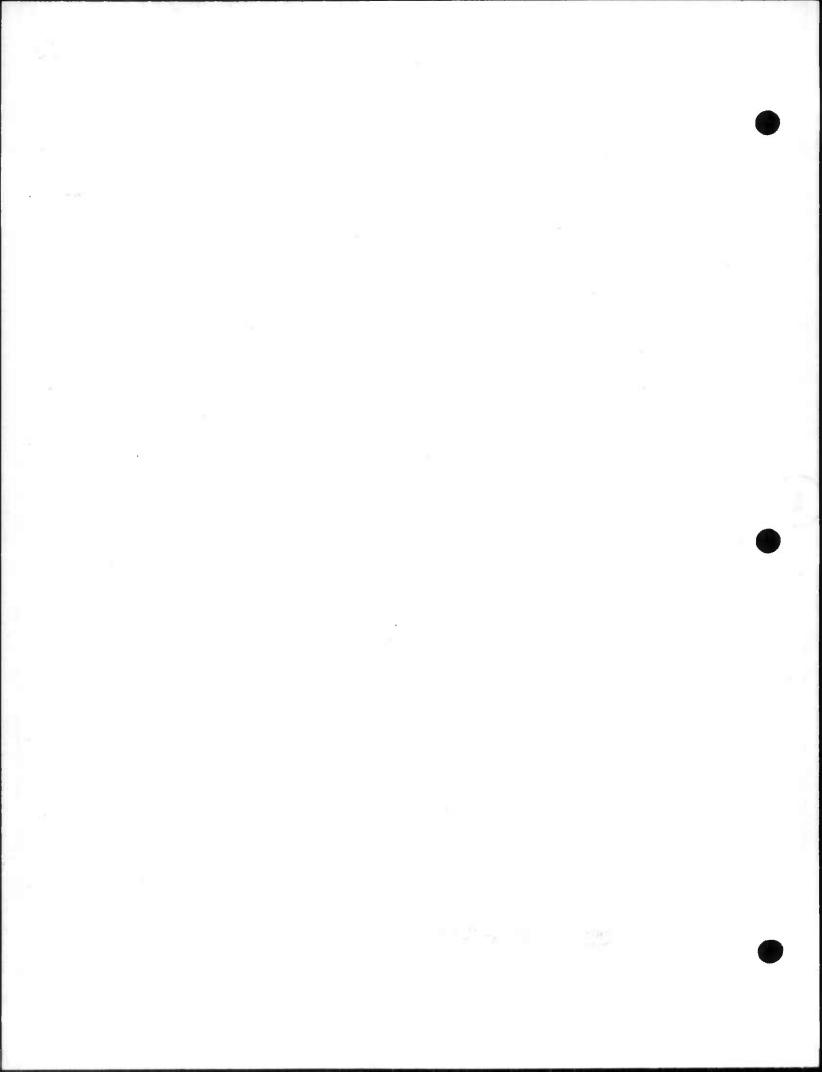
1. DECEDENT'S NAME (First, Middle, Last)

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		4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. les	t birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS	7. DATE OF BIRTH		8. BIRTHPLACE (State	or Foreign
70		212-20-7991	1 M 2 F	69	YRS.	MONTHS DAYS	HOURS MIN.	JAN . 21 , 1	926	ILLINOIS	
3 should		Sa. FACILITY NAME (If not institution, give si	reet and number)			9b. CITY, TOWN	OR LOCATION OF			TY OF DEATH	
c'	DIRECTOR	NORTH ARUN	DEL HOSP	ITAL		GLEN BU	JRNIE .		ANNE	ARUNDEL	
	EC	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY	,		10c. CIT	Y, TOWN OR LOCA	TION			10d. INSIDE	CITY
permit. Pages 1,		MARYLAND ANNE	ARUNDEL		MI	LLERSVIL	LE M. ZIP CODE			1 YES	2 [XNO
TS.	FUNERAL	319 OBRECHT RO	-				21108		7/7	S.A.	HY7
g physician. e burial-transit	BY FU	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	FORCES?	NT EVER IN U.S. ARI I YES 2 V N MAR OR DATES	MED	It yes, ap	CENDENT OF HISP secity Cuban, Maxi 3 2 NO Spe	ANIC ORIGIN? (Specify Yelcan, Puerto Rican, atc.) offy:	s or No- 1	14. RACE — American Bleck, White, etc. Specify:	
attending se as the		15. DECEDENT'S EDUC	CATION	16s. DE	CEDENT'S	USUAL OCCUPATI	ON	16b. KIND OF BU	SINESS/INDI	WH]	l I E
al or for u	LETED	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4 or 5	(GI		work done during me		, was kind of Bo	311E33/11E0	oini	
the hospital detached for once.	COMPL	12 17. FATNER'S NAME (First, Middle, Lest)	5+	P	AST0	R		LUTHER		URCH	
6 B 6	ш	CALVERT BERNARD L	OVE SR.				16. MOTHER'S I	IAN MANT I			
5 should	TO B	190. INFORMANT'S NAME (Typo/Print) CLARA K. LOVE						ERSVILLE, MA			
may be or, page		20a. METNOD OF DISPOSITION		20b. PLACE A	NDDATE	OF DISPOSITION (N	ama of			Ity or Town, State	
e e e		1 Burial 2 Cremation 3 Ramo 4 Donation 5 Other (Specify)		GLEN	HAV	EN CEMET	TERY	12/18/95 G	len B	urnie Mar	ryland
death. Pag tuneral dir I. examiner	Š	21. SIGNATURE OF FUNERAL SERVICE INC	Fall	200	-	STALL	INGS FU	NERAL HOME			
2 2 2	- 3		<u>lings Jr</u>			3111	MOUNTAI	N ROAD PASA	DENA.	MARYLAND	21122
5 5 0		23. PART i. Enter tha diseasea, or c shock, or hasrt failure. I	omplications the List only one car	it caused tha da use on each lina.	nth. Do n	ot antar the mo	oda of dying, at	ich as cardiac or reap	iratory arre	intary	oximata vai Between
fille fon,		IMMEDIATE CAUSE (Final disease or condition	TSCH	2MIC	0	An-020	211400	ATITY		Onse	t and Death
B 2 2 2		resulting in death)	DUE TO	LMIC OR AS A CONSEC	UENCE OF	7:	70110	6			CAIC
and o bur	NO	Sequentially list conditions, if any, leading to immediate	DUE TO	COR AS A CONSEC	JAC/	M (-,	AILUR	2		19	RAIL
	CAT	cause. Enter UNDERLYING CAUSE (Disease or injury	CHAU	VIC R	em	H FA	ILUNE			14	(Ar
ding tygie	CERTIFICATION	Sequentisity list conditions, if sny, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events reaulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): O ABETES MELLINE 1990 346.									east
		DART II Other elemificant condition			- 4					129	(41)
T PO T	MEDICAL	PART II. Other significant conditions	contributing to	daath but not ra	ssuiting i	n tha undariyin	g cauaa givan i	PERFOR	RMED?	24b. WERE AUTOF AVAILABLE P COMPLETION	PRIOR TO
sign Sign Heat	AED							1 TYES 2	NO	DF OEATN?	1
has been Dept. of 23 sho	CIAN:	DID TOBACCO USE CONTE	RIBUTE TO CA	USE OF DEAT	ГН ҮЕ	S NO C	UNCERTA	IND			
the ste	ICIA	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:			N (Check only one) OTHER:					
SICIAN: The certificate h the State h d, or item	PHYSI	1 Q YES 2 NO 27. MANNER OF DEATH	26a. DATE OF		28b. TIM	E OF 28c, IN.		8 Other (Specify) 28d. DESCRIBE HOW I	NJURY OCCU	IRED	
JG PHY ter this ath with	ВУ Р	1 Natural 5 Pending 2 Accident Investigation	(Month, E	hay, Year)	INJ		YES 2 NO			The b	
CTOR: At after de 28 is r	ETED	3 Suicide 6 Could not be determined	28e. PLACE C building,	of INJURY — At hor atc. (Specify)	ne, farm, s	treet, factory, offic	0	261. LOCATION (Street a City or Town, State)		Rural Route Number,	
L DIRE	PLE	29a. CERTIFIER (Check only	CIAN: To the best of	my knowledge, des	th occurre	d at the time, data	and place, and de	e to the cause(s) and man	nner as stated	1.	
UNERA	COMPL		R: On the basis of a	xamination and/or li	rveatigation	n, in my opinion, d	leath occured at th	e time, data and placa, an	d due to the	cause(a) and manner	/ as stated.
TO THE HOSPITAL OR ATTENDING PHYSICIAN: TO THE FUNERAL DIRECTOR: After this certifica be filed within 72 hours after death with the St. IMPORTANT: If Item 28 is marked, or 19.	TO BE	TOWN H. S. COM	lifole	M			29c. LICENSE N	UMBER 221 1EGLENF	≥DCC	SIGNED (Month, Day, CHBCA)	Your)
		DANIL SCHALIB		MO 30	27) (Type,	Prim) HOSPITA	CO110	E GLENF	ORNI	E MANG	con
		DEC 1 5 1995	32. REGISTRA		• •			- 13		2	1061

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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.



2. DATE OF GEATH DAY

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

JOSEPHINE LONG DECEMBER 4. SOCIAL SECURITY NUMBER 7. DATE OF BIRTH 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 238-54-6775 DAYS 1 M 2 XX 73 Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF CEATH DIRECTOR BALTIMORE CITY UNION MEMORIAL HOSPITAL RESIDENCE OF DECEDENT 10a. STATE 10c. CITY, TOWN OR LOCATION MARYLAND n/a BALTIMORE permit. 100 STREET AND NUMBER FUNERAL 10f. ZIP CODE N. MADEIRA STREET 21213 page 5 should be detached for use as the burial-transit retained by the hospital or attending physician. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-If yes, specify Cuben, Mexican, Puerto Rican, etc.)

1 YES 2 NO Specify: 1 Never Married 2 Married BY Wildowed 4 Divorced COMPLETED 15. DECEDENT'S EDUCATION 16e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) Coffege (1-4 or 5+) LABORER 3 rd ST. FATHER'S NAME S'irst, Michille, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) WILLIE WEST MC GHEE ROYSTER F CORA BE notified 19a, INFORMANT'S NAME (Typo/Print mber or Rural Route Number, City or Town, State, Zip Code)
EIRA STREET, BALTIMORE, MD 2 BONNIE BUTLER 1520 Ν. MADEIRA house attendeem. Page 6 may be pe 254 METHOD OF DISPOSITION 1 (2) Burtal 2 (2) Cremation 3 (2) F 20b. PLACE AND DATE OF DISPOSITION (Name of must DATE funeral director, KING MEMORTAL **PARK** 4 Donation 5 D pt er (Specify) 12 + 16examiner 21. SIGNATURE OF WOMERAL BERVICE LICENSEE: 22, NAME AND ADDRESS OF FACILITY WM. C. MARCH FH.-1101 E. NORTH n and completely filled in by the to bunal, cremation, or removal. the medical 23. PART In Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) Meumonia event. DUE TO (OR AS A CONSEQUENCE OF): Accordent erebrovaçcular traumatic CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF) if any, leading to immediate cause. Enter UNDERLYING been signed by the attending physician of Health and Mental Hygiene prior to death certificate be Deutenson CAUSE (Diseese or Injury other DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 6 PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. requires that the MEDICAL 24a. WAS AN AUTOPSY PERFORMED? any 1 TYES 2 NO Shows DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO 🗵 UNCERTAIN 🗆 PHYSICIAN: has be Dept. HOSPITAL OR ATTENDING PHYSICIAN: The law 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) EXAMINER? certificate to the State HOSPITAL: OTHER: Inpetient 2 - ER/Outpetient 3 - DOA 4 Nursing Home 5 Residence 8 Other (Specify) 6 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED marked, this c 1 Natural 5 Pending 1 YES 2 NO BY After 2 Accident DIRECTOR: Afr hours after de-Item 28 Is n 3 Suicide 28e. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify) COMPLETED 4 Homicide TO THE HOSPITAL OR AT TO THE FUNERAL DIRECT DE filed within 72 hours a IMPORTANT: If Item 2 29a. CERTIFIER CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated. 2 MEDICAL EXAMINER: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, data and piece, and due to the cause(s) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER oot bex 9 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) BESHAY

JULA SIGNATURE

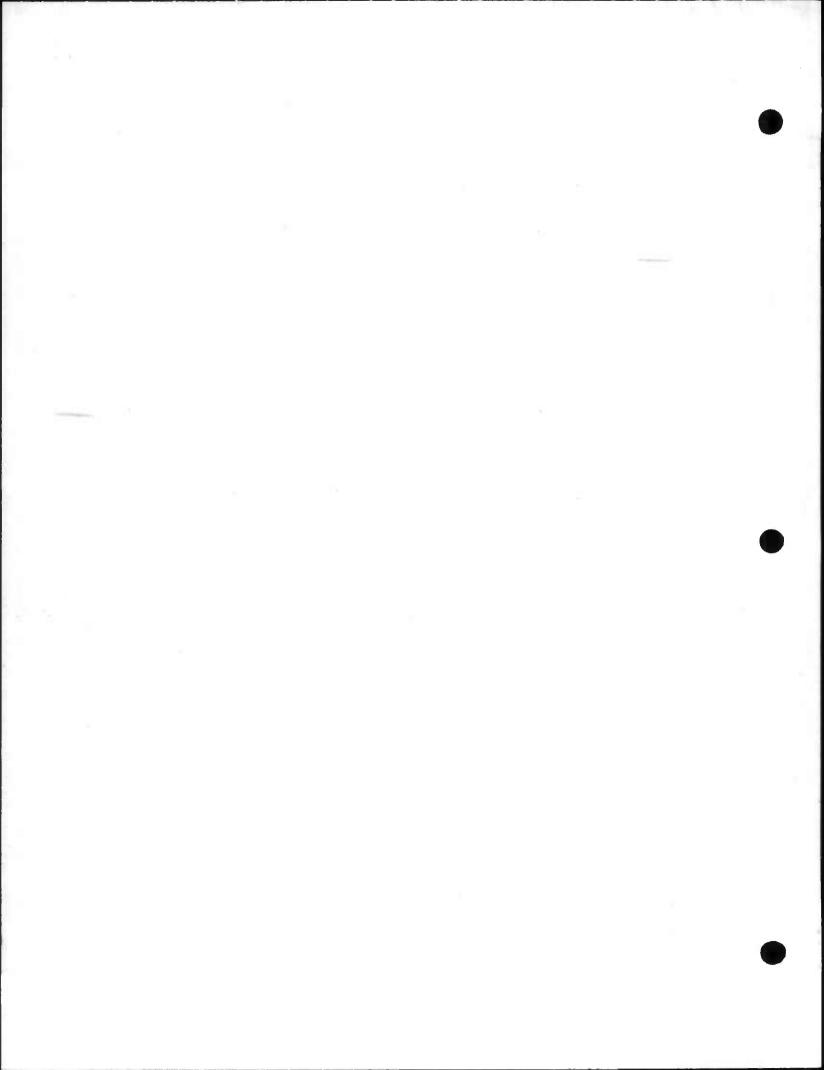
Items#10.e.19.b. G-film 730 per FH 12/15/95 P.C.
1 - STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REGISTRAR CERTIFICATE OF DEATH REG. NO.

1. DECEOENT'S NAME (First, Middle, Last)

DEC 1 5 1995

3. TIME OF DEATH 11:47 995 8. BIRTHPLACE (State or Foreign CAROLINA N. DC. COUNTY OF CEATH n/a 10d. INSIDE CITY YES 2 NO 10g. CITIZEN OF WHAT COUNTRY? UNITED STATES 14. RACE — American Indian, Black, White, etc. Specify: BLACK FISH LAUNDRY 20c. LOCATION — City or Town, State RANDALLSTOWN, MD **AVENUE** Interval Between Onset and Death mark Marth 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 TES 2 NO 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 29d. DATE SIGNED (Month, Day, Year) 11119

DHMH-16 Rev 1/89



BALTIMORE, MARYLAND 21215-0020

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	the death ce	y the attendin	nd Mental Hyg	Injury, or o
	that the death ce	ed by the attendin	h and Mental Hyg	any injury, or o
	ires that the death ce	signed by the attendin	lealth and Mental Hyg	ws any Injury, or o
	requires that the death ce	en signed by the attendin	of Health and Mental Hyg	shows any injury, or o
	aw requires that the death ce	s been signed by the attendin	ept. of Health and Mental Hyg	23 shows any Injury, or o
	he law requires that the death ce	e has been signed by the attendin	e Dept. of Health and Mental Hyg	m 23 shows any Injury, or o
	N: The law requires that the death ce	ficate has been signed by the attendin	State Dept. of Health and Mental Hyg	Item 23 shows any Injury, or o
	ICIAN: The law requires that the death ce	ertificate has been signed by the attendin	the State Dept. of Health and Mental Hyg	or Item 23 shows any Injury, or o
	HYSICIAN: The law requires that the death ce	is certificate has been signed by the attendin	vith the State Dept. of Health and Mental Hyg	ted, or Item 23 shows any Injury, or o
	G PHYSICIAN: The law requires that the death ce	er this certificate has been signed by the attendin	ith with the State Dept. of Health and Mental Hyg	narked, or Item 23 shows any Injury, or o
	IDING PHYSICIAN: The law requires that the death ce	After this certificate has been signed by the attending	death with the State Dept. of Health and Mental Hyg	s marked, or Item 23 shows any Injury, or o
	TENDING PHYSICIAN: The law requires that the death ce	TOR: After this certificate has been signed by the attendin	after death with the State Dept. of Health and Mental Hyg	28 Is marked, or Item 23 shows any Injury, or o
	R ATTENDING PHYSICIAN: The law requires that the death ce	RECTOR: After this certificate has been signed by the attendin	urs after death with the State Dept. of Health and Mental Hyg	m 28 Is marked, or Item 23 shows any Injury, or o
	L OR ATTENDING PHYSICIAN: The law requires that the death ce	 DIRECTOR: After this certificate has been signed by the attendin 	hours after death with the State Dept. of Health and Mental Hyg	item 28 Is marked, or Item 23 shows any Injury, or o
	PITAL OR ATTENDING PHYSICIAN: The law requires that the death ce	ERAL DIRECTOR: After this certificate has been signed by the attendin	n 72 hours after death with the State Dept. of Health and Mental Hyg	T. If item 28 Is marked, or Item 23 shows any Injury, or o
	HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death ce	-UNERAL DIRECTOR: After this certificate has been signed by the attendin	vithin 72 hours after death with the State Dept. of Health and Mental Hyg	ANT: If item 28 is marked, or item 23 shows any injury, or o
	HE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death ce	HE FUNERAL DIRECTOR: After this certificate has been signed by the attendin	ed within 72 hours after death with the State Dept. of Health and Mental Hyg	ORTANT: If item 28 is marked, or item 23 shows any injury, or o
	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The !aw requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hos	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detach	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial. cremation, or removal.	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, P.O. BOX 68760

	Items#11.17.20	.b.G-fi	1m 730) pe:	r FI	H. 1	2/15	5/95	P.C		9	95	3807	7
	FOR STATE REGISTRAR	STATE OF N	TARYLAND A	DEPAR	RTMEN	T OF H	EALTH DEAT	AND N	MENTAL	HYGIEN REG. NO.	E			
	1. DECEDENT'S NAME (First, Middle, Last)								2. DATE OF	DEATH	M.	WEAR	3. TIME OF OEATN	
	JOSEPH	BERNARD		LOGS	BOOM	1			D.91	12 1	995	YEAR	5:30 am	М
	4. SOCIAL SECURITY NUMBER 213-40-1867	5. SEX	6. AGE (In yrs. Ia	st birthday) YRS.	IF UNDE	DAYS	HOURS	24 HRS. MIN.	7. DATE OF (Month, (April	BIRTH Boy, Marry 1	909	8. BIRTI- Countr	IPLACE (State or Fore	ilgn
	9e. FACILITY NAME (If not institution, give str	reet and number)			9b, CIT	Y, TOWN (PR LOCATIO			30,1		NTY OF O		
OR	Saint Joseph Medica	al Center				Tows	on, M	aryla	ind			Itimo		
FUNERAL DIRECTOR	100. STATE 106. COUNTY Ba	ltimore		10c. CIT	у, томун ТС	OR LOCATOWS ON	TION						10d. INSIDE CITY LIMITS?	
AL	10s. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHA													
ER	205 East Joppa	Road					21:	286				U.S	.A.	
B≺	11. MARITAL STATUS 1 A Never Married 2 Merried 3 Widowed 4 Divorced	12. WAS DECEDEN FORCES? 1 IF YES, GIVE W	YES 2	RMED NO	13	If yes, sp	ENDENT O	1, Mexicar	IIC ORIGIN? (n, Puerto Ric	Specify Yes an, atc.)	or No-			
ED	15. DECEDENT'S EDUC (Specify only highest grade of		16a. O	ECEDENT'S	USUAL	OCCUPATION	ON .		16b. K	INO OF BUS	INESS/INC	DUSTRY		
COMPLETED	Elementary/Secondary (0-12)	College (1-4 or 5 +)				st of workin							
MP	12	N/A	Rea	iltor	& S	pecu	lato:					Ind	ustry	
00	17. FATHER'S NAME (First, Middle, Last) Olman Orman	Joseph		Logs	don				ME (First, Mid Cathe:					
B		оозери	10			e /Street e								_
2	196. INFORMANT'S NAME (Type/Print) Anita P. Logsdon 195. MAILING ADDRESS (Street end Number or Rural Route Number, City or Town, State, Zip Code) 205 E. Joppa Road Towson, Maryland 21286										6			
l.	20e, METHOD OF DISPOSITION 1 (X Burlet 2 Cremetton 3 The place Town, State 20b. PLACE AND DATE OF DISPOSITION (Name of Cametery, cremetory of other place) 4 Donation 5 Other place Dullaney Valley Mem. Gardens 1214 Timonium, Maryland													
	Lowell Lemmon 22. NAME AND ADDRESS OF FACILITY Lemmon Funeral Home of Dulaney, I 10 West Padonia Road, Timonium, N								, Inc.	93				
	23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) a. MASSIVE GASTROINTESTINAL BLEEDING									Approximate interval Bet Onset and I 4 HOUR	e ween Death			
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): MALIGNANT LYMPHOMA DUE TO (OR AS A CONSEQUENCE OF): INFLAMMATORY AORTIC ANEURYSM STATUS POST REPAIR													
	PART II. Other algolificant conditions	contributing to	death but not i	resulting	In the u	nderlying	cause g	iven in I	Part I. 24	In. WAS AN		24b.	WERE AUTOPSY FINE	
MEDICAL	GLAUCOMA/CATA	RACTS				=			_	PERFOR	Y		AMILABLE PRIOR TO COMPLETION OF CAL OF DEATH? 1 YES 2 NO	USE
AN	DID TOBACCO USE CONTR	IBUIE IO CA		E OF DEA			UNC	ERTAIN	1					
22	EXAMINER?	NOSPITAL:			OTHE	R:								
Y PHYSICIAN:	27. MANNER OF DEATH 1 Neturel 5 Pending	28a. OATE OF (Month, Da	INJURY	28b. TIM	_	28c. INJ WO			6 Other (S		JURY OC	CURED		
TED BY	2 Accident Investigation 3 Suicide 8 Could not be 4 Homicide determined	28s. PLACE Of building,	FINJURY — At he atc. (Specify)	ome, ferm, s	street, fac				281. LOCATION OF 1	DN (Street a fown, State)	nd Number	or Rural R	loute Number,	
COMPLET	29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSIC 2 MEDICAL EXAMINER) and menner as stat	ed.
ш	2 MEDICAL EXAMINER: On the beels of examination end/or investigation, in my opinion, death occured at the time, data and piece, end due to the cause(e) and menner as stated. 29b. SIONATURE AND TITLETOF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year)													
TO B	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type Print)									2-95				

30. NAME AND ADDRESS OF PERSON WNO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

LISA PICHNEY, MD 7505 OSLER DRIVE, SUITE # 307; TOWSON, MARYLAND 21204

31. DATE FILED (Month, Day, Year)

DEC 1 5 1995

July 2016

32. REGISTRAR'S SIGNATURE



8. BIRTHPLACE (State or Foreign Country)

10d. INSIDE CITY LIMITS? 1 YES 2 NO WHAT COUNTRY?

21215

Approximate Interval Batween Onset and Death

24b. WERE AUTOPSY FINDINGS MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?

1 - YES 2 - NO

end due to the cause(e) end menner se stated. 29d, DATE SIGNED (Month, Day, Year)

REG. NO.

December 12

2. DATE OF DEATH MONTH DAY

		212-22-3268 1 M 2 K F 70 YRS. MONTHS DAYS HOURS MIN. 3-12-1925- COUNTY	
2, 3 should	OR	90. FACILITY NAME (If not institution, give etreet end number) Center Baltin 82	EATH /A
Pages 1,	DIRECTOR	100. STATE 100. COUNTY 100. COUNTY Baltinore	10d. INSIDE CIT LIMITS?
n. Insit permit.	FUNERAL	100. STREET AND NUMBER W. Coldspring Lane 101. ZIP CODE 109. CITIZEN OF	
5-0020 nding physician. ss the bunial-transit	BY FUN	11. MARITAL STATUS 1 Never Married 2 Merried 3 Widowed 4 Divorced 12. WAS DECEDENT EVER IN U.S., ARMED FORCES? 1 YES 2 NO If yes, apecify Cuben, Maxicen, Puerto Ricen, etc.) 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No— If yes, apecify Cuben, Maxicen, Puerto Ricen, etc.) 1 YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No— If yes, apecify Cuben, Maxicen, Puerto Ricen, etc.)	E - American India, White, etc.
2121 al or atte	COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed) 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use refired.) 16b. KIND OF BUSINESS/INDUSTRY (Give kind of work done during most of working life. Do NOT use refired.) 16c. KIND OF BUSINESS/INDUSTRY 16c. KI	rites
7 8 8 7	l m	17. FATHER'S NAME (First, Middle, Leat) 18. MOTHER'S NAME (First, Middle, Meiden Surname) Ally Pope	
E, Pe		199_INFORMANT'S NAME (Type Edit) 190_INFORMANT'S NAME (Type Edit) 190_INFORMATT'S NAME (Type Edit) 190_INFORMANT'S NAME (Type Edit) 190_IN	
F 6 m		1 Surial 2 Cremation 3 Removal from State Configury, crematory or other place) 4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY	
EALTH. Purple to the funeral of removal.		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,	elto, nd
rithin 24 hour		induction of the state of the s	Approxin Interval I Onset ar
BOX 687(ficate be executed physician and corr ne prior to burial,	CATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLY/ING CAUSE (Disease or injury that initiated events b. Severe chronic obstructive Lung discovered to the consequence of: COTONGTY CITTETY disease. DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):	36226
S, P. death of attend ental Hy	CER	PART II. Other significant conditions contributing to deeth but not resulting in the underlying ceuse given in Part I. 24s. WAS AN AUTOPSY 241	b. WERE AUTOPSY
ECOR quires that n signed b	8	PERFORMED? 1 □ YES 2 NO	AWAILABLE PRIOR COMPLETION DF OF DEATH? 1 YES 2
L law		DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one)	
N. Th N. Th State		EXAMINER? 1 YES 2 NO HOSPITAL: 1 Inpetient 2 ER/Outpetient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify)	
O 옷 왈룩 및		27. MANNER OF DEATH 1 Netural 5 Pending 2 Accident Investigation 28e. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY AT WORK? 1 YES 2 NO 28d. DESCRIBE HOW INJURY OCCURED	
DIVISION OR ATTENDING P DIRECTOR: After hours after death	<u>a</u>	3 Suicide 6 Could not be determined 28e. PLACE OF INJURY — At home, ferm, street, factory, office building, etc. (Specify) 28e. PLACE OF INJURY — At home, ferm, street, factory, office City or Town, State) 281. LOCATION (Street and Number or Rural City or Town, State)	Route Number,
4 7 K 5		29e. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. 2 MEDICAL EXAMINER: Do the best of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(a).	e) end menner ee
TO THE HOSPIT TO THE FUNERA De filed within 7	TO BE	296. SIGNATURE AND TITLE OF CERTIFIER AHENDING Phys. D30115 296. Date SIGNED 12	(Month, Day, Year
		30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) T. UNIOICPENSI, MD 2600 LIBERTY HAT AVE BRIT, MD	21215
		DEC 1 5 1995	

1. DECEDENT'S NAME (First, Middle, Last)

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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

Morton

DHMH-16 Rev 1/89



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	- STATE REGISTRAR			TE OF DE	TH AND MENT ATH	REG. NO.				
		m R.	Mur		Dec	ember 13 19				
	4. SOCIAL SECURITY NUMBER 217-34-59699	t XX 2 □ F	58 YRS. MON	THS DAYS HOU	MIN. Ju	ne 12,1937	I. BIRTHPLACE (State or Foreig Country) VA			
CTOR	90. FACILITY NAME (If not institution, give 6717 Laure	el Dr.	96.	Balti		7.00	y of death /a			
DIREC	RESIDENCE OF DECEDENT 10a, STATE 10b, COUR MD			wn or Location	e		10d. INSIDE CITY LIMITS? 1 X \$\frac{1}{2} \$\text{\$\texitt{\$\text{\$\text{\$\texit{\$\texi{\$\texi{\$\text{\$\tex{\$\text{\$\text{\$\text{\$\text{\$\text{\$\texit{\$\text{\$\texi{\$\text{			
ERAL	10e. STREET AND NUMBER 6717 Laure			101, ZIP C		t0g. CITIZ	EN OF WHAT COUNTRY?			
BY FUN	11. MARITAL STATUS 1 Never Married 2 Xarried 3 Widowed 4 Divorced	12. WAS DECEDENT EVER I FORCES? 1 TYES IF YES, GIVE WAR OR D	2 No		uban, Maxican, Puari		(Specify Yes or No— 14. RACE — American Indian,			
LETED	t5. DECEDENT'S El (Specify only highest gra Elementary/Secondary (0-12)	life. Do NOT use ret	done during most of w red.)		66. KIND OF BUSINESS/INDU					
E COMPL	12th 17. FATHER'S NAME (First, Middle, Last) Hezekiah Mur	Clerg	y 18. N							
TO B	19a. INFORMANT'S NAME (Type/Print) Joyce Murray 20a. METHOD OF DISPOSITION				nber or Rural Route No Dr. Bal	to, MD 2	1207			
RTIFICATION	23. PART I. Enforthe diseases, or shoul, or heart failur IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that inflated events resulting in death) LAST	a	CONSEQUENCE OF): A CONSEQUENCE OF):				st, Approximate interval Betwood Onset and D			
SICAL CE	PART II. Other algoriticant condition	lona contributing to death t	but not resulting in th	ne underlying cau	ae given in Part i.	24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FIND AMAILABLE PRIOR TO COMPLETION OF CAU OF DEATH?			
	DID TOPACCO LICE COA	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one)								
	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLACE OF DEATH (C	heck only one)		the County	1 - YES 2 - 100			
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL	HOSPITAL: 1 Inpetient 2 ER/Out 26e. DATE OF INJURY (Month, Day, Year)	26. PLACE OF DEATH (Copations 3 DOA 4 DOA 1NJURY	HER: Nursing Home 5 26c. INJURY A WORK? M 1 YES	Residence 6 🗆 0	ther (Specify) DESCRIBE HOW INJURY OCC				
TED BY PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2	HOSPITAL: 1 Inpetiant 2 ER/Out 26e. DATE OF INJURY (Mortin, Day, Year) 26e. PLACE OF INJURY building, stc. (Spe	28. PLACE OF DEATH (C patient 3 DOA 4 DOA 4 DOA 1 DOA	HER: Nursing Home 5 26c. INJURY A WORK? M 1 YES	Residence 6 0 0 T 28d. 0 2 NO 28f. L		URED			
ETED BY PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 3 27. MANNER OF DEATH 1 Natural 5 Pending trivestigation of the detarmined detarmined 29a. CERTIFIER (Check only)	HOSPITAL: 1 Inpetiant 2 ER/Out 26e. DATE OF INJURY (Mortin, Day, Year) 26e. PLACE OF INJURY building, stc. (Spe	26. PLACE OF DEATH (C petilent 3 DOA 4 DOA 4 DOA 4 DOA 4 DOA 4 DOA 1 DOA	heck only one) HER: Nursing Home 5 26c. INJURY WORK? M 1 YES I, factory, office	Rasidence 6 0 0 T 2ad. 0 2 NO 2ar. L	DESCRIBE HOW INJURY OCCI OCATION (Street and Number of Iny or Youn, State)	URED or Rural Route Number, d,			
ED BY PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 3 27. MANNER OF DEATH 1 Natural 5 Pending trivestigation of the detarmined detarmined 29a. CERTIFIER (Check only)	HOSPITAL: 1 Inpellant 2 ER/Out 26e. DATE OF INJURY (Month, Day, Year) 26e. PLACE OF INJUR building, stc. (Spe IYSICIAN: To the best of my know IINER: On the basis of examination	26. PLACE OF DEATH (C patient 3 DOA 4 D 26b. TIME Of INJURY Y — At home, tarm, stree city) wiedge, death occurred at on and/or investigation, in	heck only one) HER: Nursing Home 5 26c. INJURY WORK? M 1 YES It, factory, office the time, data and p my opinion, death c	Rasidence 6 0 0 T 2ad. 0 2 NO 2ar. L	OCATION (Street and Number of Town, State) cause(a) and manner as state sets and place, and due to the	or Rural Route Number,			



C103

DHMH-18 Rev 1/89

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 14 months and only page 5 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and comparing the comparing the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If them 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF	MARYLAND /	DEPARTMENT	0F	HEALTH	AND	MENTAL	HYGI	ENE
	CI	ERTIFICATE	OF	DEAT	TH		REG	NO

	1 - FOR STATE REGISTRAR	STATE OF MARYLA		NT OF HEALTH AND TE OF DEATH	MENTAL HYGIEI						
	1. DECEOENT'S NAME (First, Middle, Lest)	EITH n	MORROL	U	2. DATE OF DEATH MONTH		3. TIME OF DEATH				
	4. SOCIAL SECURITY NUMBER 5. 5. 1			IDER 1 YEAR IF UNDER 24 HRS. HS DAYS HOURS MIN.	7. DATE OF BIRTH	65 BAL	BIRTHPLACE (State or Foreign Country) TIMORE, MD				
OR		HOSPITAL	9b. (BALTIMORE	CITY 9c. COUNTY OF DEATH						
DIRECTOR	RESIDENCE OF DECEDENT 100. STATE MARYLAND 10b. COUNTY	n/a	10c. CITY, TOV	ON OR LOCATION BALTIMORE							
FUNERAL	100. STREET AND NUMBER 816 WHITELO		101. ZIP CODE 2121	7	10g. CITIZEN	TED STATES					
BY FUNI	11. MARITAL STATUS 1 Mevrer Merried 2 Merried 3 Widowed 4 Divorced	2. WAS DECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR DA		13. WAS DECENDENT OF HISP, If yes, specify Cuben, Mexical YES 2 X NO Specify Cuben, Mexical YES 2 X NO Specific Research	can, Puerlo Rican, etc.)	ee or No- 14.	RACE — American Indian, Black, While, etc. Specify: BLACK				
COMPLETED	15. DECEDENT'S EDUCAT (Specify only highest grade con Elementary/Secondery (0-12) 12 th	ION npleted) College (1-4 or 5+)	life. Do NOT use retir	one during most of working	51-01000	USINESS/INDUS	CITY				
ш	17. FATHER'S NAME (First, Middle, Lest) JEROME MORRO)W	1000 1	18, MOTHER'S N	AME (First, Middle, Maide IRLEY BON	n Sumame)					
TO B		SON		HESS (Street and Number or Rura HITELOCK ST	REET, BALT						
	1 [X] Muriel 2 Cremetion 3 Remova 4 Donation 5 Other (Specify)	20e. METHOD OF DISPOSITION 1 X Muriei 2 Cremetion 3 Removal from State 4 Donating 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of CEDAR PILL CEMETERY 12- 16 ANNE ARUNDELCO., md									
	21. SIGNATURE OF PUNERAL SERVICE LICEN:	hones-0	Xves	WM. C. MARC		E. N	NORTH AVENUE				
ATION	23. PART I. Enter the diseases, or complications that caused this desth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or haart failure. List only one cause on aach lina. IMMEDIATE CAUSE (Final disease or condition resulting in death) Approximate interval Between Onset and Daath Approximate interval Between Onset and Daath But To (OR AS A CONSEQUENCE OF): Due To (OR AS A CONSEQUENCE OF):										
CERTIFICATION	cause. Enter UNDERLYING CAUSE (Disease or Injury that Initiated avents resulting in death) LAST d										
MEDICAL C	Renal Failu	contributing to death be	ut not rasuiting in the	underlying cause given i		N AUTOPSY DRMED?	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?				
	DID TOBACCO USE CONTRIB		F DEATH YES [IN 🗆		1 TYES 2. THO				
PHYSICIAN:	1 YES 2 NO 1	IOSPITAL: PCInpatient 2 - ER/Output	itlent 3 DOA 4 D	IER: Nursing Home 5 - Residence	6 Other (Specify)						
	27. MANNER OF OEATH 1 Notural 5 Pending Investigation	28e. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK? 1 YES 2 NO	28d. OEŞCRIBE HOW	INJURY OCCUR	(ED				
TED BY	2 Accident Investigation 3 Suicide 8 Could not be determined	28e, PLACE OF INJURY building, etc. (Speci	At home, ferm, street,	fectory, office	281. LOCATION (Street and Number or Rural Route Number, City or Town, State)						
COMPLET	999)			he time, date end place, end do			euse(e) and manner se stated,				
TO BE C	295. SIGNATURE AND TITLE OF CERTIFIER	14	M.D.	20c. LICENSE N	791	29d, DATE S	1GNED (Month, Day, Year) 2/13/95				
	30. NAME AND ADDRESS OF PERIOD WHO COMMARK J, KAMI 31. DATE FILED (MORITI, Day, Year)	NSKI M	D 22	S. Green St	· Balti	more	MD 21201				
	DEC 1 5 1995	Studior Rand									

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 95

						Certificate of	f Death		Reg. No.	0 (
	-		1. Decedant's Name (First, Middla, L	ast)				2. Data of De	ath	Yaar	3. Time of I	Death
	Physic /Medi		Jackson F	· .	M	OORE		Dec.	Dey 12, 19	95	6:57	a.m
Ça,	Exami		4e. Facility Nama (If not institution, gi	iva street and number)			4b. City, Town, or L	ocation of Deeth	4c. County	of Death		
			Franklin Square				Rossvil		Balti	more		
	Funeral Director		5. Social Security Number 6. 239–30–3170 Usuel Residence of Decedant	Sax 7. Age (I	71	Months Dey		8. Data of Birt (Month, Da Dec • 20,	r, Year) 1923	9. Birthpl Count North	lace (State or try) Caroli	Foreign na
	fland fland		10e. Stata 10b. County	10	c. City, Town	or Location				10	Od. Insida City	Limits
	Man	to	Md. Baltin	nore		Essex					1 ☐ Yes	Z∏ No
	h with the 23a or 28	al Director	10e. Street and Number 1 Cardinal Lane	2		10f. Zip Code	1221	10g. Citizen of What USA				
020	hours after death with the Maryland turet, or items 23a or 28s-f show at Examinet must be nutified at	by Funeral	11. Maritai Status 1 Nevar Married 2 Married 3 Widowed 4 Divorced	12. Was Decedant Eva Armed Forces? typ Yes 2 No If Yas, Giva Yaar or Dates: 4.		13. Was Decedent of ft Yas, specify Cu			ce - Amarican Indian, ack, Whita, etc. Ty: White			
5-0	in 72 hours 1 "natural", Lod cal Exa	peter	15. Decedant's E (Specify only highast gi		16a.	Decedent's Usual Occi	upation	kina	16b. Kind of Bu			
21215-0020	within ene.	Completed	Elemantery/Secondary (0-12)	Collega (1-4or 5+)	יע	(Give kind of work don life. DO NOT usa ratir RECTOR . (a during most of work od) DF - LLG	wy	MAN	AGE	MENI	_
	Hyging the the		12th 17. Fethar's Neme (First, Middle, Las	nt)			18. Mothar's Nam		Maidan Sumam	na)		
Maryland	0 5 5 9	To Be	Posie Jack					nnie M				
ary	d 2 should th end Men 7 Is marke traumatic	-	19a. Intormant's Name/Ralationship		19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Steta, Zi							
	475 d		Margaret Moore		1	Cardinal 1	Lane Bal	timore	Md. 212	21		
ore	8 5 5		20e. Mathod of Disposition		20b. Place of	Disposition (Nama of		Date	20c. Location -		wn, Steta	
Amo	Pages nent of I ant: If Ite ury or o		1 Starial 2 ☐ Cramation 3 (4 ☐ Donation 5 ☐ Other (Spec			Hill Cemet		5/95	Baltin	more	Md.	
Baltimore,	permit. Page Department of Important: If eny Injury or once.		21. Signature of Funeral Sarvice Lice	Cornel	4	_	Funeral H			4		
1	_		23a. Part1. Entar the disease, or con shock, or heart failure. List only	nplicetions that caused the	daeth. Do n	ot antar tha moda of dy	Ave. Balt ing, such es cardiec	or raspiratory as	d. 2122 rast,	1	Approximate	
þ	Physician /Medical Examiner		Immediata Causa (Final disaasa or condition rasulting in death)	aRe	spir	onseguence of	errest	•			Interval Betw Onset and De	
		Jer		Dy	to (or as a c	onsequence off.						
60,	eath certificate be executed attending physician and for use as the burial-transit	al Examiner	Sequentielly list conditions, if any, laading to immediate causa. Enter Underlying Causa (Disaese or injury	Ь.	-001	o (Juance ot):	٠,			1		
Box 68760,	onding physics as the	In/Medical	that initiated avants rasulting In daath) Last	d	onsequance of):							
	death he atter ed for u	sicia	Part tt. Other significant conditions	contributing to death but n	ot rasulting in	the underlying causa g	iven in Pert I.	23b. Did 1	obacco usa cor	ntribute to	the cause of	death?
P.0	iras that the de signed by the a d be detached t	by Physician/	CAD	with his	tong.	of CHF		10	res 2 No	3 Prob	ebly 4 🗆 U	nknown
of Vital Records,	need shoul	Completed b	му	astrenia	His	ves			an autopsy med?	con	ra autopsy fin illabla prior to inpletion of ca leath?	
æ	0 - 0	E O	He	merleus	~~			101	es 2 No	10	Yas 2DN	lo
'ita	ysician: The	Be	25. Was casa rafarred to medical axaminar?				26. Placa of Dea	th (Check only o	na)			
> >	5 00 0	To	1 Yas 2 No	Hospital: 1 Inpatiant	2 X ER/Out	patient 3 DOA	thar: 4 Nursing H	ome 5 Rasid	lance 6 DOth	ar (Specify	')	
ion	or Attending Phatier death. Director: After the in by the funeral		27. Manner of Death 1 Natural 5 ☐ Panding 2 ☐ Accident investigation	28a. Data of Injury (Month, Day Ye	28b. Ti	jury W	ury et ork? □ Yas 2 □ No	28d. Dascribe h	now Injury occur	ed		
Division	al or Atte s after de il Directo ed in by th	Certification:	3 ☐ Suicide 6 ☐ Could not t 4 ☐ Homicida detarmined		At homa, fan	m, street, fectory, office	9	28f. Location (S City or Tox	Street and Numb m, Steta)	er or Aurai	Routa Numb	θΓ,
	To the Hospital or Att within 24 hours after of To the Funeral Direct completely filled in by	edicai	29a. Certifier 1 Certifying Pl (Check only one) 2 Medical Exa	hysician: To the best of m miner: On the basis of axe and mannar stated	minetion and	death occurred at that /or invastigation, in my	time, date end plece opinion, daeth occur	end due to the cred at tha tima,	ceuse(s) and ma data and place,	nnar as ste and due to	ated. tha cause(s)	
	To the within 2 To the comple	M	29b. Signatura and titla of certifier			29c. Licer	nse number		29d. Date signe			
1	6		Ronald (Utarasi	OM	D-	28097		12-1	2-9	5	
	(0)		30. Nama and address of person who	completed causa of death	(Itam 23a) (1	Type, Balt.,	Md.	2102	f.			~~~
	Sta Registr		31. Data tiled (Month, Day 995) DEC 1 5 1995	A Stationary	Signatural							

Registrar

at William Man and A. . The many of the same of the con-

SAUTIMORE, MARYLAND 21215-0020	the dark. Page 6 may be retained by the hospital or attending physician.	for infinity director, page 5 should be detached for use as the burial-transit permit, Pages 1, 2, 3 sho noval.	cal examiner must be notified at once.	
DIVISION OF VITAL RECORDS, P.O. BOX 6876	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 from the day be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once,	

	1 - STATE REGISTRAR	STATE OF N	/MARYLAND Ce				DEAT		MENTA	REG. NO.			
1	1. DECEDENT'S NAME (First, Middle, Lest) GRACE	MERS							2. DATE MONTE	OF DEATH		75 3.	TIME OF DEATH 45 PM
	4. SOCIAL SECURITY NUMBER 217-56-5962	5. SEX	6. AGE (In yrs. last	birthday)	IF UNDER	1 YEAR DAYS	IF UNDER	24 HRS. MIN.	7. DATE (Mont)	OF BIRTH 1, Day, Year) 25/1936	7		CE (State or Foreign
	9e. FACILITY NAME (If not institution, give sti	reet and number)	33		9b. CITY	, TOWN C	OR LOCATH	ON OF DE		.5/1950	9c. COUNT		
OR	Mercy Hospital				Balt	imo	re					N/A	
נל	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY			10c, CIT	Y, TOWN (OR LOCAT	TION					10	d. INSIDE CITY
DIRECTOR	MARYLAND N/	A				timo							LIMITS?
FUNERAL	100. STREET AND NUMBER 3107 Belair Rd.	-					21213				10g. CITIZE		T COUNTRY?
BY	11. MARITAL STATUS 1 Never Married 2 Married 3 Wildowed 4 Divorced	T EVER IN U.S. AR YES 2 WA	MED		If yes, sp		n, Mexica	n, Puerto I	I? (Specify Yea Rican, etc.)	l l	RACE — Block, W Ameri	American Indian, hits, stc. Can	
윤	15. DECEDENT'S EDUC (Specify only highest grade		/G/	ve kind of	USUAL O	CCUPATIO	ON ost of working	g	16b	KIND OF BUS			
Ē	Elamentary/Secondary (0-12)	College (1-4 or 5	+) life.	Do NOT U	se retired.)	_				G N	. Auto	2	
COMPLETED	12th 17. FATHER'S NAME (First, Middle, Last)	0		Mipt	icer		18 MOTI	IFR'S NA	ME /First I	Middle, Malden			
E C	Stafford Locklear								xend		Juliane		
TO B	190. INFORMANT'S NAME (Type/Print) Randy Locklear									ber, City or Town			
	20a. METHOD OF DISPOSITION 1	oval from Stata	20b. PLACE A					У	12/		ation — ci		Steta aryland
	21. SIGNATURE OF EMIERAL SERVICE LIC	EMBEE / /	/		22.	NAME A	ND ADDRE	SS OF FA	CILITY				
	Tathleen	We	lur	_	_		-			I. 401			r St.
	23. PART I Enter the diseases, or contact of the co	ist only one cau	ise on each line					ing, suci	h ss cer	disc or respli	ratory arres	st,	Approximate interval Between Onset and Death
	Tooling in sealing		(OR AS A CONSEC						-				1
ATION	Sequentielly list conditions, if any, leading to immediate cause. Enter UNDERLYING	DUE TO	(OR AS A CONSEC	DUENCE C	F):				-	-			
CERTIFICATION	CAUSE (Disease or Injury that Initiated events resulting in death) LAST	DUE TO	(OR AS A CONSEC	DUENCE O	F):								
CE		1											
MEDICAL	PART II. Other algnificent condition	e contributing to	death but not r	eeuiting	In the ur	nderlyin	g ceuse (given in	Part i.	24a. WAS AN PERFOR	MED?	CC OF	ERE AUTOPSY FINDINGS AILABLE PRIOR TO IMPLETION OF CAUSE DEATH?
	DID TOBACCO USE CONTE	RIBUTE TO CA	USE OF DEA	TH Y	ES 🔲	NO Z	UNC	ERTAI	N 🔲			1	YES 2 NO
SICIAN	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLAC	E OF DEA	TH (Check		_						
XSI	1 YES 2 NO	1 Inpatient 2	ER/Outpetient 3	v	4 🗆 Nui	ming Hon	ne 5 🗆 Re	sidenca		r (SpecifyHO)			AT MERCY
Y PHY	27. MANNER OF DEATH 1 Netural 5 Pending Investigation	28a. DATE OF (Month, E		28b. TII	JURY M	WC	JURY AT DRK? YES 2	NO	28d. DE	SCRIBE HOW IF	IJURY OCCU	RED	
ETED BY	2 Accidem 3 Suicide 8 Could not be detarmined		OF INJURY — At ho atc. (Specify)	me, tarm,	atreet, tec	tory, offic	on .		28t. LOC City	ATION (Street a or Town, State)	nd Number o	Rural Rout	e Number,
COMPLE	29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICONE) 2 MEDICAL EXAMINE											nd menner as stated.	
	29b. SIGNATURE AND TITLE OF CERTIFIER						29c, LIC	ENSE NUI	MBER		29d. DATE	SIGNED (M	onth, Day, Year)
TO BE	Prondate et	auli	acom)			7)	251	04	3	▶15	14/0	75
	HR FAULKNE	/				nee	EY K	20)	/ B	aeto	M>	212	04
	DEC 1 5 1995	32. REGISTA	AR'S SIGNATURE	3									

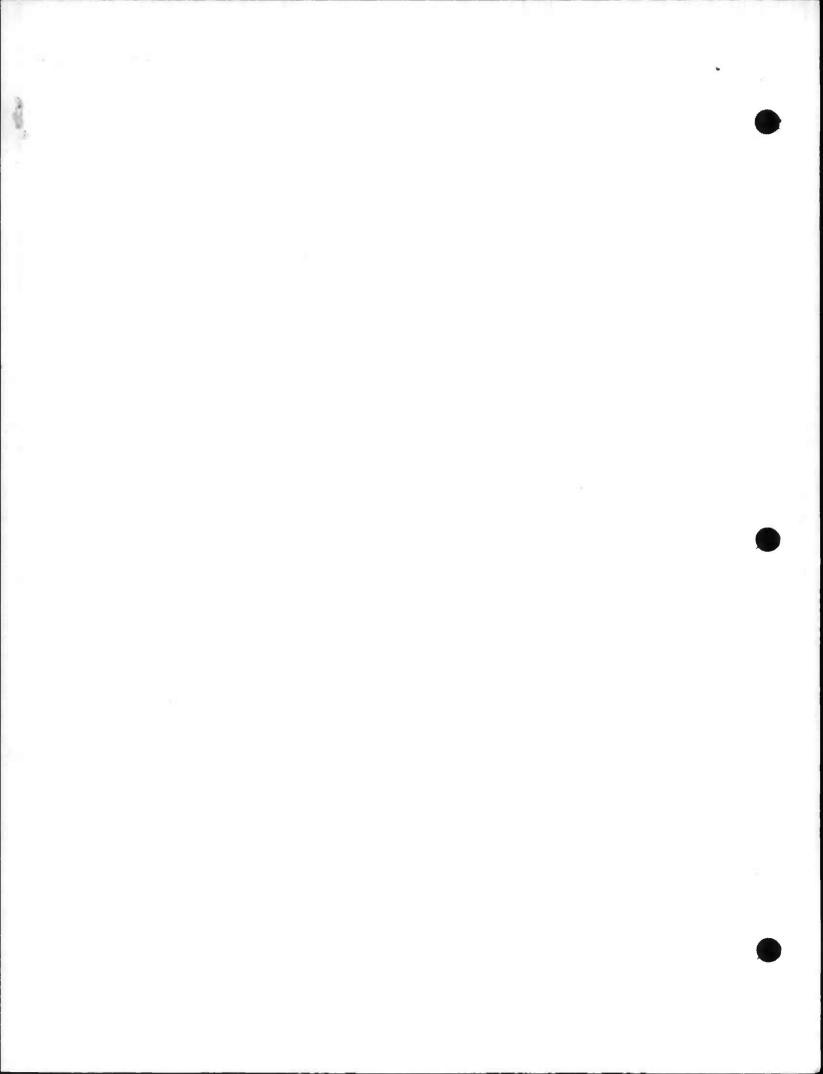


TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be encuted with a found of the Hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and competity flind in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial event, the medical examinater must be notified at once. BANTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760,

	FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPARTI			MENTAL HYGIEN				
	1. OECEDENT'S NAME (First, Middle, Last)				DE7 (11)	2. DATE OF DEATN		3, TIME OF DEATN		
	CLIFFORD	FRANCIS	MARTON	1		DECEMBER "	7 1995	8:00 A M		
	4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE		F UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTN	8. BIRT	NPLACE (State or Foreign		
	217-42-0230 9s. FACILITY NAME (If not institution, give st									
TOR	8823 BALTIMORE	STREET		SAVAG			HOWARD			
DIRECTOR	10e. STATE 10b. COUNTY MD Howar			rage	ION			10d. INSIDE CITY LIMITS?		
	10e, STREET AND NUMBER				710 0005		L 40. 0/7/70/1 0.0	1 TES 2 NO		
FUNERAL	100. STREET AND NUMBER 8823 Baltimore Street 101. ZIP COOE 102. CITIZEN OF WN. USA							WNAT COUNTRY?		
	11. MARITAL STATUS 1 Never Merried 2 Merried	12. WAS DECEDENT EVER I FORCES? 1 YES	2 X NO	If yes, sp	cify Cuben, Mexica	NIC ORIGIN? (Specify Yearn, Puerto Rican, atc.)	Biac	E — Americen Indien, ck, White, atc.		
D BY	3 Widowed 4 Divorced	IF YES, GIVE WAR OR D			2 X NO Specif			White		
COMPLETED	15. DECEDENT'S EDUC (Specify only highest grade Elementary/Secondery (0-12)	completed) College (1-4 or 5+)	16a. DECEDENT'S US (Give kind of work life. Do NOT use n	k done during mo	N st of working	16b. KIND OF BU	SINESS/INDUSTRY			
AP.	TOTAL CONTRACT OF THE PARTY OF	None	Security	agenc	Y	Dept. o	f defens	e		
ŏ	17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NA	ME (First, Middle, Maiden	Sumeme)			
BE	Clyde Raymond Ma	rton			Thelma	Clara Mar	tin			
10	196. INFORMANT'S NAME (Type/Print) Marcia A. Marton	(Spouse)				Route Number, City or Tow Vage, MD	n, State, Zip Code) 20763			
	20e. METHOD OF DISPOSITION 1 X Burial 2 Cremetion 3 Remo	200	D. PLACE AND DATE OF I	DISPOSITION (Ne			CATION — City or T	оwп, State		
	4 Donetton 5 Other (Specify)	I.	netery, cremetory or other	metery	13,	1995 Lau	rel, MD			
	21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEE	-			sell C Wit				
	23. PART I. Enfer the diseases or c	complications that cause	d tha death. Do not					Approximata		
	ahock, or haart fallure. If	. Glioblas		ULTIF	orme			Interval Between Onset and Death		
z		DUE TO (OR AS	A CONSEQUENCE OF):					'		
ATIO	Sequentially list conditions, If any, leading to immediate cause. Enter UNDERLYING	DUE TO (OR AS	CONSEQUENCE OF):							
CERTIFICATION	CAUSE (Disease or injury that initiated eventa resulting in death) LAST	DUE TO (OR AS A	A CONSEQUENCE OF):							
	DARVI II. Oak al-aliia alii									
DICAL	PART II. Other significant condition	a contributing to death b	out not resulting in t	tha underlying	cause given in	Part i. 24a. WAS AN PERFOR	MED?	b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?		
PHYSICIAN: MEDIC	DID TOBACCO USE (CONTRIBUTE TO	CAUSE OF I	DEATH Y	ES NO	- 1621 C		1 Tes 2 No		
IA.	25. WAS CASE REFERRED TO MEDICAL				ACE OF DEATH (Ch	CAR .				
SIC	EXAMINER?	HOSPITAL: 1 Inpetient 2 ER/Out		THER:	5 Residence	8 Other (Specify)				
PHY	27. MANNER OF DEATN	28e. DATE OF INJURY (Month, Day, Year)	28b. TIME C	F 28c, INJ	URY AT	28d. DEŞCRIBE HOW I	NJURY OCCURED			
ВУ	1 Natural 5 Pending 2 Accident Investigation			M 1 1	ES 2 ND					
COMPLETED	3 Suicide 8 Could not be 4 Homicide determined	28e. PLACE OF INJURY building, etc. (Spe	/ — At home, ferm, stre cify)	et, fectory, office		28f. LOCATION (Street of City or Town, State)	end Number or Rural	Route Number,		
29e. CERTIFIER (Check only Check only CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end piece, end due to the ceuse(s) end menner es stated.										
MO		R: On the beele of examination						s) end menner se stated.		
BE C	296. SIGNATURE AND TITLE OF CERTIFIER	101			29c. LICENSE NUI	MBER	29d. DATE SIGNE	D (Month, Day, Year)		
TO B	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF DE	ATH (ITEM 27) (Time Pr	int)	D38500	· · · · · · · · · · · · · · · · · · ·		ber 8 1995		
	NUHULIAS W. KOU	TIZE LAKES H	063446	Palus	ent Phu	ry Column	bIH MD	21044		
	DEC 1 5 1995	32. REGISTRAR'S SIGN	ATURE				III III			





FOR STATE REGISTRAR

1 -

REG. NO.

BALTIMORE, MARYLAND 21215-0020 ours after death, Page 6 may be retained by the hospital or attending physici

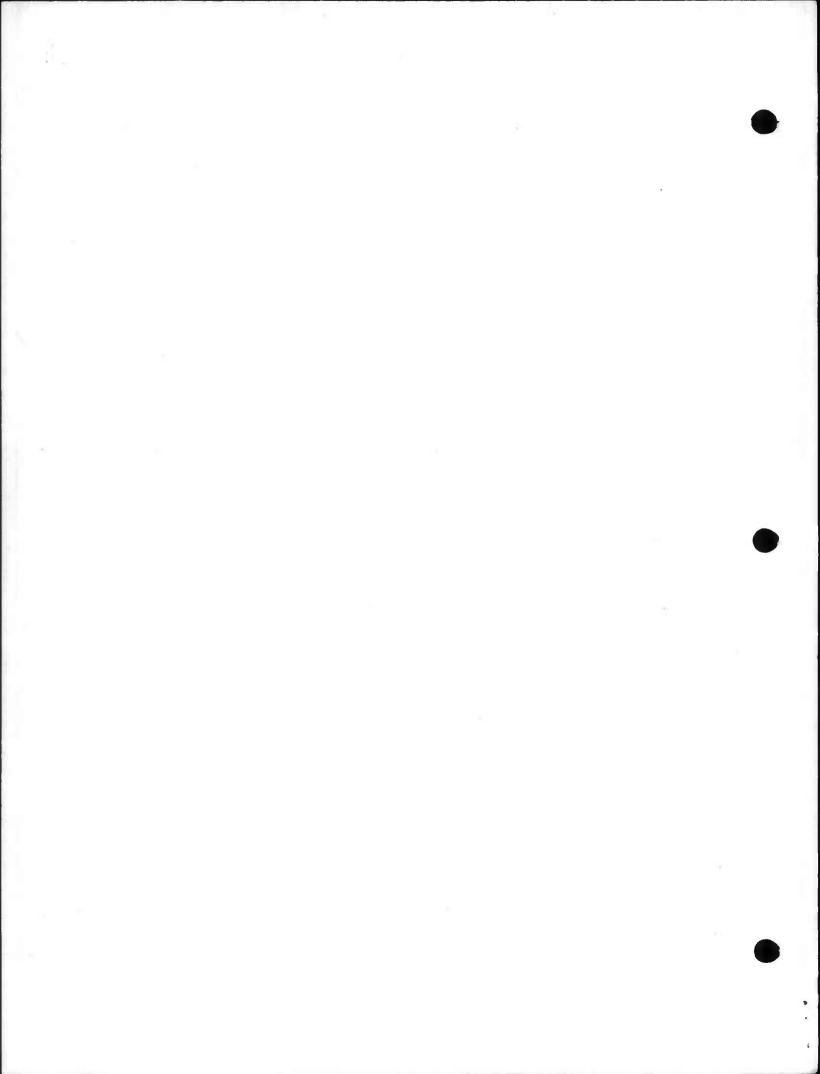
Georg In

DIVISION OF VITAL RECORDS, P.O. BOX 68760
HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within the control of the

1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH DECEMBER DAY 1995 BABY GIRL MCDONALD 1845P 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR 7. DATE OF BIRTH A. BIRTHPLACE (State or Foreign MIN. 45 DAYS 1 M 2 J N/A Dec. 1,1995 Maryland Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR St. Agnes Hospital Baltimore N/A 10a. STATE 10b. COUNTY 10c, CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Baltimore Catonsville permit. 1 YES 2 NO 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 605 Hilton Avenue iay be retained by the hospital or attending physician, page 5 should be detached for use as the burial-transit 21228 U.S.A. 11 MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-if yes, specify Cuban, Maxican, Puerto Rican, etc.) 14. RACE --- American Indian, Black. White, atc. 1 Never Married 2 Married FORCES? 1 YES 2
IF YES, GIVE WAR OR DATES 1 YES 2X NO Specify: B 3 Widowed 4 Divorced White ETED. 15. DECEOENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY ive kind of work done Do NOT use retired.) Elementary/Secondery (0-12) College (1-4 or 5+) COMPL N/A N/A N/A 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Patrick McDonald notified at Danielle Ellis BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Danielle McDonald (Mother) Hilton Avenue Catonsville, Maryland 21228 605 Pe 20a. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of OATE 20c. LOCATION - City or Town, State must 1 t Buriel 2 Cremetion 3 Re 4 Donation 5 Other (Specify) funeral director, Metro Crematory Dec. 7,1995 Catonsville, Maryland examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND AGORESS OF FACILITY Leroy M & Russell C Witzke Funeral Homes vesselle 1630 Edmondson Avenue Catonsville, Maryland medicai 23. PART i. Enter the diseases, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heert failure. Liet only one ceuse on each line. interval Batween 6 filled IMMEDIATE CAUSE (Final **Onset and Death** the cremation, disease or condition Prematurity 31 weeks resulting in death) event, DUE TO (OR AS A CONSEQUENCE OF) and com Hydrops fetalis 31 weeks traumatic CERTIFICATION Sequentially list conditione, DUE TO (OR AS A CONSEQUENCE OF): prior to if any, leading to immediate cause. Enter UNDERLYING other t CAUSE (Disease or injury attending phyene pental Hygiene p DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST the atten PART II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 24s. WAS AN AUTOPSY PERFORMED? MEDICAL a de апу Signed to Health air NYTES 2 | NO OF DEATH? Shows 1 YES 2 NO peen 0 DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO E has be Dept. PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) EXAMINER? State certificate NOSPITAL:
1/E/Inputlent 2 - ER/Outpetlent 3 - DOA OTHER 4 - Nursing Home 0 the 27. MANNER OF DEATH 28a. OATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 28b. TIME OF 28d. OESCRIBE HOW INJURY OCCURED marked, with w 1 Natural 2 Accident 5 Pending Investigation 1 YES 2 NO BY After 28e. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify) 3 Suicide DIRECTOR: Al hours after de item 28 is .52 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 8 Could not be 4 Momicide 29e. CERTIFIER 1 💢 CERTIFYING PHYSICIAN: To the beat of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. TO THE HOSPITAL OF THE FUNERAL DE FILE WITHIN 72 HOSPITANT: IT IN MEDICAL EXAMINER: On the basic of axamination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(a) and manner as stated. 29c. LICENSE NUMBER 29d. OATE SIGNED (Month, Day, Year) BE D43453 December 2, 1995 TEO CAUSE OF DEATH (ITEM 27) (Type, Print) Dixon King, Jr., M.D. St. Agnes Hospital 900 Caton Ave., Balt., MD 21229 22. REGISTRAR'S SIGNATURE 1995

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH



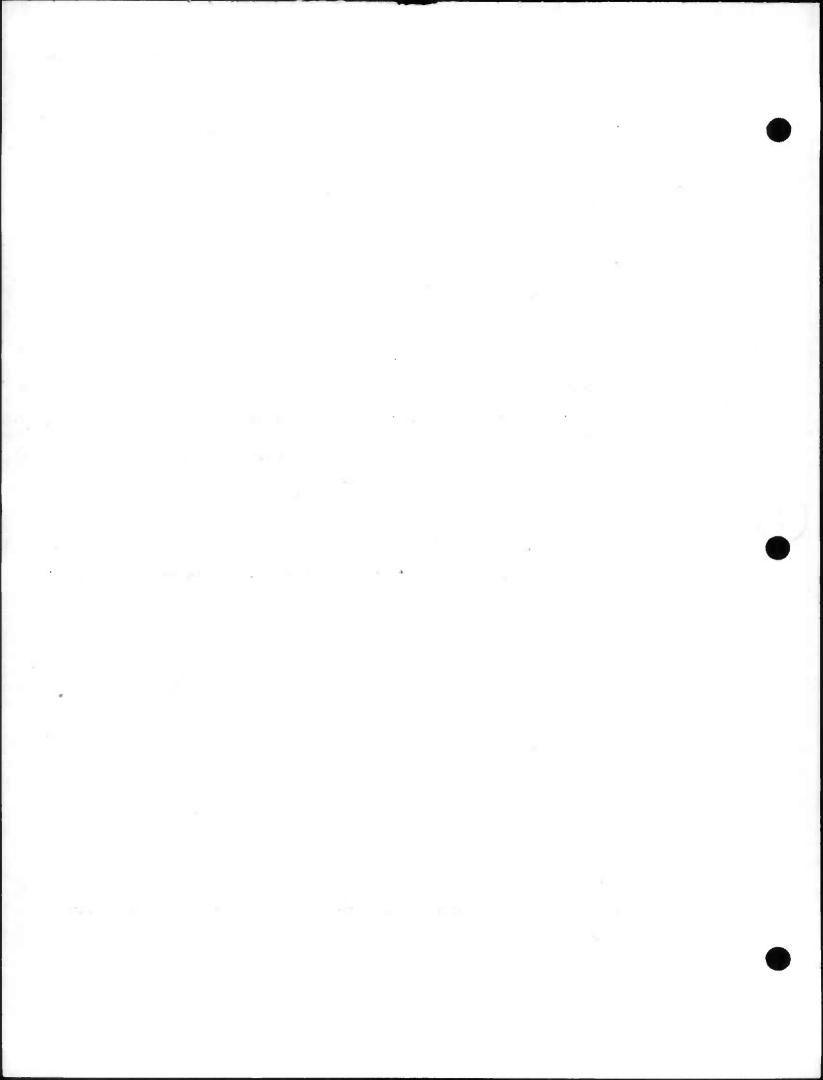
FOR STATE REGISTRAR

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	1. DECEDENT'S NAME (First	, Middle, Last) MitCh	ell							MONTH	of OEATH D	~ I	1995	TIME OF DEATH	4
	4. SOCIAL SECURITY NUME		5. SEX		yrs. last birthday)	IF UNDER	DAYS		24 HRS.	7. DATE (DE BIRTH		a. BIRTHPL Country)	ACE (State or Foreign	-
	129-16-55		1 🗆 M 2 💢 F	70) YAS.	MONTHS	LIATE	HOUNS	MINT.	Jan	28,1		New	York	
or l	9a. FACILITY NAME (If not in							OR LOCATI		EATH			NTY OF DEA	тн	
DIRECTOR	Johns Hop		Bayview	M.C	•	Ва	lti	more)			N/A	1		_
1 H	10e. STATE	10b. COUNT			10c. Cl	ry, town (OR LOC	ATION					1	Dd. INSIDE CITY	-
	Maryland	Ba 1	timore		N,	/A							t	☐ YES 2 X NO	
ERAL	10e. STREET AND NUMBER						1	of. ZIP COD				10g. CIT		AT COUNTRY?	
Ä	6941 Geri	man H					\perp	2122				L.,	USA		_
BY FUN	11. MARITAL STATUS t Never Married 2 X 3 Wildowed 4 Divo		12. WAS OECEDEN FORCES? 1 IF YES, GIVE W				If yes, s	ECENDENT OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF T	n, Maxica	an, Puarto f	? (Specify Ya lican, atc.)	a or No—	14. RACE - Black, \ Specify:	- American Indian, White, atc. White	
COMPLETED		EDENT'S EDU		1	6a. DECEDENT'S	work done	during n	TION nost of world	na	16b.	KIND OF BU	SINESS/INC	DUSTRY		-
	Elementary/Secondary (6		College (1-4 or 5		life. Do NOT (ise retired.)									
MP	8				House	vife		-			Own H				_
	17. FATHER'S NAME (First, M Kenneth							1/1		Heal	fiddle, Maiden	Surname)			
出	ton, INFORMANT'S NAME (_	T 100 MAILIN	C ADODES	¢ /Steno				er, City or Tou	on Chain 76	Cartal		-
임	William		tchell					n Hi						d 21222	
	204, METHOD OF DISPOSIT	ION		20b.P	LACE AND DATE		_			DATI	- Y		City or Town		-
	1 A Burial 2 Crematic		noval from State	- Ga 1	ery, cremetory or rdens	other place)	Fai	th C	em	12-1	5 Ba	ltim	ore.	Md	
	21. SIGNATURE OF FUNERA	L SERVICE LI	CENSEE		11	22.	NAME	AND ADDRE	SS OF FA	ACILITY					-
	Anthony Colt Cornelly Connelly Funeral Home of Dundalk 7110 Sollers Point Rd 21222														
	23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart failure. List only one cause on each line.											-			
	IMMEDIATE CAUSE (Fin													Onset and Death	
	disease or condition reculting in death)	\rightarrow	Ische	mic	Bowel									Howa	
	Poorly-Differentiated Adenocarcinoma of unknown primary Year										y Vean				
NO	Sequentially list condit				ONSEQUENCE		-	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			001,51,	01117	Philo	, , , , , ,	_
CAT	if any, leading to imme cause. Enter UNDERLY	ING													
Ĕ	CAUSE (Disease or injuthat initiated events		DUE TO	(OR AS A C	ONSEQUENCE	OF):									-
CERTIFICATION	resulting in death) LAS	T .	d					_							
	PART ii. Other significe	ent conditio	ns contributing to	death but	not resulting	in the u	nderlyi	ng ceuse	given in	Part i.	24s. WAS AN		24b. W	ERE AUTOPSY FINDINGS	1
DICAL											PERFO		0	WAILABLE PRIOR TO OMPLETION OF CAUSE	
NED												. 64		F DEATH?	
7	DID TOBACCO U	ISE CONT	TRIBUTE TO CA	USE OF	DEATH Y	ES 🗆	NO I	UN(CERTAI	N 🗆					
SICIAN	25. WAS CASE REFERRED T EXAMINER?	O MEDICAL	HOSSITAL	26	. PLACE OF DE			e)							_
VSI(1 TES 2 NO		HOSPITAL:	ER/Output	lent 3 🗆 DOA	4 Nu		ome 5 🗆 R	aaldenca	8 🗆 Othe	r (Specify)				
PHY	27. MANNER OF DEATH 1 Notural 5	Pending	28a. DATE OF (Month, D		28b. TI	ME OF JURY	٧	NJURY AT VORK?		28d. DES	CRIBE HOW	INJURY OC	CURED		
B	2 Accidant	investigation	20- 81405 0	E IN HIRV	At here the	M		YES 2 [_ NO				-11110		_
ETED	4 Homicide	Could not be datarmined	building,	atc. (Specify	At homa, farm.	street, rac	nory, on	rica			ATION (Street or Town, State		r or Hurai Hou	ne Number,	
COMPL	one)		BICIAN: To the best of ER: On the beals of a											and manner as stated.	
ш	296. SIGNATURE AND TITLE								ENSE NU					fonth, Day, Year)	-
0 8	2000 51	'ox,						9	601	5		▶ <i>l</i>)ecem	ber 11, 1995	,
-	TOdd S. C	F PERSON W	D John	se of DEAT	kins Ba	e, Print) 44°eu	NI	1edic	as Ce	enter.	Balti	more	MD	21224	
	DEC 1 5 19									/		-10-	, ,		_

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

DHMH-16 Rev 1/89



TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burlal-transit permit. Pages 1, 2, 3 should	be filed within 72 hours after death with the State Dept, of Heatth and Mental Hygiene prior to bundal, cremation, or removal.	indoorant it has 20 to marked or item 20 shows any injury or other traumatic event the medical examiner must be notified at once
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	11.	611150D 17-1	J-75 11	Img. J	0				
	FOR STATE REGISTRAR	STATE OF MAI				EALTH AND DEATH	MENTAL HYGIEN REG. NO	-	
!	1. DECEDENT'S NAME (First, Middle, Last) Margaret Mary	O'Connel	.1					13 19	78.7.70 =
	4. SOCIAL SECURITY NUMBER 219-60-5417	1 M 2 💢 F	AGE (In yrs. last b	YRS. MON	UNDER 1 YEAR	IF UNDER 24 HRS. HOURS MIN.	The state of the s	1906 °	New York
-	9a. FACILITY NAME (If not institution, give s		~~			OR LOCATION OF		9c. COUNTY	
0	Villa Assumpts	a,6401 N.	Char	les 2	t. I	Baltimo	re	Balt	imore
DIRECTOR		timore		6401	N OR LOCA	harles	s, Baltime	ore	10d, INSIDE CITY LIMITS7 1 YES 2 NO
IAL I	10e. STREET AND NUMBER				10	. ZIP CODE		10g. CITIZEN	OF WHAT COUNTRY?
FUNERAL	6401 N. Charle					21212		US	
	11. MARITAL STATUS 1 Naver Married 2 Married	12. WAS DECEDENT E FORCES? 1	VER IN U.S. ARMI YES 2 THO	ED			ANIC ORIGIN? (Specify Years, Puarto Rican, atc.)		RACE — American Indian, Black, White, etc.
B	3 Widowed 4 Divorced	IF YES, GIVE WAR	OR DATES			2 XNO Spi			specify: White
	15. DECEDENT'S EDU (Specify only highest grade	completed)	(Give		JAL OCCUPATION done during motioned is		16b. KIND OF BU	ISINESS/INDUST	RY
COMPLETED	Elementary/Secondary (0-12)	College (1-4 or 5+)	reac				Educa	ation	
N	17. FATHER'S NAME (First, Middle, Last)	<i>)</i> +				18. MOTHER'S	NAME (First, Middle, Malde		
	John O'Connell	L				Marga	ret Quin	1	
BE	19a. INFORMANT'S NAME (Type/Print)	-	196.	MAILING AD	DRESS (Street		al Route Number, City or To		le)
유	S.Bernice Feil	linger	64	+01 N	. Cha	rles S	t. Balt:	imore.	Md. 21212
	20a, METHOD OF DISPOSITION 1 T Burlal 2 Cremation 3 Ram	oval from Stata	20b. PLACE AN	ID DATE OF D	ISPOSITION (N	ame of	DATE 20c. L	OCATION — City	
	4 Donation 6 Other (Specify)		NOLLE	Dame	±a-Ce	emetery	G.	len Ar	m, Md.
	21. SIGNATURE OF FUNERAL SERVICE LIC	CENSEE	_		22. NAME A	ND ADDRESS OF	FACILITY - WIEDER	CIST	
	tohic	7760)		6500	YOUX	RO Bal	to M	D 21212 0
	23. PART I. Enter the diseases, or			th. Do not	enter tha mo	oda of dylng, s	uch as cardiac or res	olratory arreat,	
	shock, or heart fallura. IMMEDIATE CAUSE (Final	A	on each lina.	cal	Die	1201	1 /	' /	Interval Batween Onset and Death
	disease or condition resulting in death)	· A	sugar	161	ever	ic Ca	COUNTY WIFE	r disc	AK UK
		DUE 70 (0)	AS A CONSEQUE	ENCE OF):		/ - 1	rdiovasula plucum		0.
Z	Sequentially list conditions,	· Cli	nonie	145	DIVHI	200	procum	NIA	Menths
CERTIFICATION	If any, leading to immediate cause. Enter UNDERLYING	DUE TO (OI	R AS A CONSEOL	JENCE OF): /	'				
	CAUSE (Disease or injury that initiated events	c. DUE TO (OI	R AS A CONSECU	JENCE OF):					
	resulting in death) LAST								
S		d							
A	PART II. Other algnificant condition	na contributing to de	ath but not ra	sulting in t	he underlyin	ig cause givan	in Part I. 24a. WAS A PERFO	N AUTOPSY ORMED?	24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO
MEDICAL							1 YES	2 P NO	OF DEATH?
ME									1 TES 2 100
PHYSICIAN:	DID TOBACCO USE CONT	RIBUTE TO CAU					NN L		
SICI/	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:		0	Check only one,	5.5 (10			
IX S	1 YES 2 NO	1 Inpetient 2 E		26b. TIME O			28d, DESCRIBE HOW	IN HIRV ACCUR	
	1 Natural 5 Pending	(Month, Day,		INJUR	r W	JURY AT ORK? YES 2 NO	28d. DESCRIBE HOW	INJUNY OCCUM	EU
	2 Accident Investigation	28a, PLACE OF I	NJURY — At hom	ne, ferm, etre			26f. LOCATION (Stree	t and Number or F	Rural Route Number
COMPLETED	3 Suicide s Could not be 4 Homicide datarmined	building, sto	c. (Specify)				City or Town, Stat	0)	
	29a. CERTIFIER 1 CERTIFYING PHYS	ICIAN: To the best of m	knowledge dest	th occurred a	t the time dat	a and place, and	fue to the cause(a) and m	enner se stated	
BE COMPLE	none)								use(a) and menner as stated.
S	29b. SIGNATURE AND TITLE OF CERTIFIE	b		-		29c. LICENSE	IUMBER	29d, DATE SI	GNED (Month, Day, Year)
BE	180	~				DIS	871		114/95
인	30. NAME AND ADDRESS OF PERSON W					, , , ,			111/1
	Dr. Lawrence H	Boas, M.D	. 54 8	cott	Adam	Rd.,	Cockeysvi	ille,	Md. 21030
	31. DATE FILED.(Month, Day, Year)	32. REGISTRAR	SIGNATURE						
	DEC 1 5 1995	in to smarter an	HERANGE.						
	X 6 1444								DMMH-1/6 Rev 1/80

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	FOR 1 STATE	STATE OF MARYL	AND / DEPAR	TMENT OF H	EALTH AND I	MENTAL HYGIEN	E	
	REGISTRAR		CERTIF	ICATE OF	DEATH	REG. NO.		
	1. DECEDENT'S NAME (First, Middle, Last)		EN TOUR OF TOUR	_		2. DATE OF DEATH	AY YE	3. TIME OF DEATH
		JOSEPH OPSZ		,			11, 19	
	4. SOCIAL SECURITY NUMBER		(In yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS. HOURS MIN.	7, DATE OF BIRTH (Month, Day, Year)	0.1	BIRTHPLACE (State or Foreign Country)
	218-28-7890		63 YRS.			Nov. 24.	1932	Maryland
= 1	9e. FACILITY NAME (If not institution, give st				R LOCATION OF DE	ATH	9c. COUNTY	
0	6604 Raven Hill	L Road		Loch	Hill		Balti	more County
5	RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY	,	10c CIX	Y. TOWN OR LOCAT	ION			10d. INSIDE CITY
DIRECTOR		imore County		ltimore-		1		LIMITS?
	10e. STREET AND NUMBER	inole country	Da		ZIP CODE	<u> </u>	100 CITIZEN	1 TYES 2 NO
FUNERAL		D 1		1.01				
W	6604 Raven Hill	KOACI	WILE ADMED	12 44 050	21239	IIC ORIGIN? (Specify Yes		USA RACE — American Indian,
F	1 Never Married 2 Married	FORCES? 1 VES	2 NO	If yes, sp	cify Cuben, Mexica	n, Puerto Rican, etc.)	14.	Black, White, stc.
BY	3 Widowed 4 Divorced	Korean	ATES	1 TYES	2 NO Specify	r,		Specify: White
E	15, DECEDENT'S EDUC	CATION	16a. DECEDENT'S	USUAL OCCUPATION	DN	16b. KIND OF BU	SINESS/INDUST	
ET	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4 or 5+)	(Give kind of life. Do NOT u	work done during mo se retired.)	st of working			
릴		4 years	Electr	ician		Steel C	ompany	
COMPLET	17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NA	ME (First, Middle, Maiden		
BE C	Anthony Opszentl	kowski			Anna	NMN		Lisa
	19a, INFORMANT'S NAME (Type/Print)		19b. MAILING	ADDRESS (Street e	nd Number or Rural I	Route Number, City or Tow		
2	Mrs. Carroll A. (Opszentkowski	i 6604	Raven Hi	ll Road.	Baltimore	. Marv	land 21239
	20a, METHOD OF DISPOSITION 1 ☑ Buriel 2 ☐ Cremetion 3 ☐ Remo			OF DISPOSITION (Na			CATION — City	
	4 Donation 5 Other (Specify)	D	ulanev V	allev Me	n. Grdns	12/15 Tir	nonium.	Maryland
	21. SIGNATURENCE FUNCTION LIST	ENSEE		22. NAME AP	ID ADDRESS OF FA	CILITY	,	,
	Martin D.	vison				defeld Hom		1 1 04040
	23. PART I. Enter the diseases, or o	complications that ceuse	d the death. Do	not enter the mo	de of dylng, suc	h aa cardlac or reep	Iratory arrest	, Approximate
	ahock, or heart fellure. IMMEDIATE CAUSE (Finel	Liet only Dne ceuse on e	ech line.					intarval Between Onset and Death
	disease or condition	. Panoreatic	Cancon					6mar
	resulting in death)		A CONSEQUENCE O	OF):				411103
z		h						
CERTIFICATION	Sequentially ilat conditions, if any, leading to immediate	DUE TO (OR AS	A CONSEQUENCE O	PF):				
CA	cause, Enter UNDERLYING CAUSE (Disease or injury	С						
E	thet initieted events	DUE TO (OR AS	A CONSEQUENCE O	OF):				
ERI	resulting in death) LAST	d						
- 1	PART II. Other algnificant condition	s contributing to deeth i	out not resulting	In the underlying	cause given in	Pert I. 24s. WAS AN	AUTOPSY	24b. WERE AUTOPSY FINDINGS
S			-			PERFOI		AVAILABLE PRIOR TO COMPLETION OF CAUSE
ED			-		-	1 YES 2	SKI NO	OF DEATH?
Σ	DID TOBACCO USE CONTI	PIRLITE TO CALISE O	DE DEATH Y	FS I NO I	UNCERTAIL			1 WES 2 NO
AN	25. WAS CASE REFERRED TO MEDICAL	CIBOTE TO CAUSE C		ATH (Check only one)	ONCERNA	, 6		
PHYSICIAN: MEDICAL	EXAMINER? 1 YES 2 NO	HOSPITAL:	netlect 3 DOA	OTHER:	s V Destance	6 Other (Specify)		
ΗX	27. MANNER OF DEATH	28a. DATE OF INJURY	28b. Til	ME OF 28c, INJ		28d. DESCRIBE HOW	NJURY OCCUR	ED
	1 Netural 5 Pending	(Month, Day, Year)	IN		PRK?			
ВУ	2 Accident Investigation 3 Suicide 8 Could not be	28e. PLACE OF INJUR	Y — At home, term,	street, lectory, offic	• .	281. LOCATION (Street	and Number or I	Rural Route Number,
回	4 Homicide determined	building, etc. (Spe	icify)			City or Town, State)	
COMPLET	290. CERTIFIER 1 X CERTIFYING PHYSI	ICIAN: To the best of my know	riedge death occur	red at the time state	and place and dis-	to the cause's and	Ones an eleted	
MP	(Orlock Orly)							euse(e) end manner ee stated.
	296. BIGNATURE AND TITLE OF CENTIFIES							
BE	Z. III W	,			29c. LICENSE NUI		29d. DATE SI	2/12/95
٩	30. NAME AND ADDRESS OF PERSON WH	O COMPLETED CAUSE OF D	EATH (ITEM 27) / In	n (Palant)	11 3070	4	1	2/10/17)

Johns Hopkins Oncology Center, Baltimore, MD 21205-2009

OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

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	FOR STATE REGISTRAR			DEPARTM ERTIFIC		DEATH AND		REG. NO.	E		
	1. DECEDENT'S NAME (First, MIC ALBERT	C. OWENS					DECE	MBER DA	13, 19	195 1	2100 P
	4. SOCIAL SECURITY NUMBER 215-12-4830	1 🔀 M 2 🗆 F	6. AGE (In yrs. Ia:	YRS. MON	UNDER 1 YEAR THE DAYS	IF UNDER 24 HRS.	Apri	DE BIRTH Day, Year)	1921	Maryla Maryla	
TOR	9a. FACILITY NAME (If not institu Church Home RESIDENCE OF DECES	Hospital		90.		ltimore	EATH			N/A	
DIRECTOR		Db. COUNTY		10c. CITY, TO	WN OR LOCAT	TION				10d	. INSIDE CITY
	Maryland	Baltimore				llawn					YES 2 X NO
RAL	10e. STREET AND NUMBER				101	f. ZIP CODE	17			O P	COUNTRY?
BY FUNER	5919 Centra 11. MARITAL STATUS 1 Never Married 2 M Ma 3 Widowed 4 Divorce	12. WAS DECEDE FORCES? IF YES, GIVE	NT EVER IN U.S. AF 1 X YES 2 WAR OR DATES	RMED NO	If yes, sp	2120 ENDENT OF HISPA Healty Cuben, Maxico 3 2 M NO Specific	NIC ORIGIN	7 (Specify Yea tican, atc.)	1	Black, Wh Specify:	
		d 1942–1		CEDENT'S USU	AL OCCUPATO	ON	166	KIND OF BUS	SINESS/MDII		White
PLETED	(Specify only his Elementary/Secondary (0-12)	ghest grade completed)	(C)	ive kind of work . Do NOT use re .ntenan	done during mo ired.)	ost of working	3011	.S. Po			ce
COMPL	17. FATHER'S NAME (First, Middle Joseph Alber					Effie E			Surname)		G A
TO BE	19a. INFORMANT'S NAME (Type Florence V.					and Number or Rural Avenue V					28
	20a. METHOD OF DISPOSITION 1 X Burial 2 Cremation 4 Donation 6 Other (Sp	3 Removal from State	20b. PLACE cemetery, co	ANDDATE OF D	isposition (Manager)	pec. 18,1 Cemeter	1995 ^{ATE}	Gar	cation - c		st, Maryl
	23. PART I. Enter the dise	a, Wath	S coused the d	eath. Do not	Leroy 1630		ssell on Ave	enue C	atons	ville	l Homes Marylan
	iMMEDIATE CAUSE (Finei disease or condition resulting in death)	DESCRIPTION OF THE	ISTOLE	o.							Onset and Des
	resulting in death)		O (OR AS A CONSE								
ATION	Sequentially list condition if any, lesding to immedia csuse. Enter UNDERLYING	na, DUE T	CARDIA		RCTIO	N					60 MINU
CERTIFICATION	CAUSE (Disease or injury that initiated eventa resulting in desth) LAST	C	O (OR AS A CONSE	OUENCE OF):							
AL	PART II. Other algnificant	conditions contributing t	o death but not	resulting in t	he underlyin	ng cause given in	Part i.	24a. WAS AN PERFOR	RMED?	CO	RE AUTOPSY FINDING
PHYSICIAN: MEDIC	DID TOPACCO LISE	E CONTRIBUTE TO C	ALISE OF DE	TU VEC		UNCERTAI	INI FX				OEATH?
AN	25. WAS CASE REFERRED TO I			CE OF DEATH			IN E.				
SIC	EXAMINER?	HOSPITAL: 1 □ Inpetient 2	KER/Outpatlant		THER: Nursing Hor	ne 5 🗆 Realdence	6 🗆 Othe	r (Specify)			
ву рну	27. MANNER OF DEATH 1 Natural 5 Per 2 Accident Inv	28a. DATE 0 (Month,	Dey, Year)	26b. TIME O	W	JURY AT ORK? YES 2 NO	28d. OES	CRIBE HOW	NJURY OCC	JREO	
	3 Suicide 8 Co	ould not be termined 28e. PLACE building	OF INJURY — At h g, atc. (Specify)	ome, farm, atre	et, factory, offic	ce		ATION (Street or Town, State)		or Rural Route	Number,
							e to the car	use(s) and ma			
COMPLETED	cool only	YING PHYSICIAN: To the best AL EXAMINER: On the basis of									d menner as stated.

BALTIMORE

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DHMH-16 Rev 1/89

CHURCH
31. DATE FILEO (Month, Day, Year)
DEC 1 5 1995

OME HOSPITAL
32. REGISTRAR'S SIGNATURE
Murchen Randalf

20.5

TO THE MOSPITAL, OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed without a first hours. Plage 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68769

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REGISTRAR

CERTIFICATE OF DEATH

CECCEPT'S NAME (First, Middle, Lust)

2. DATE OF DEATH MONTH

MONTH

DAY

- 3	HOWARD LEE PATTERSON					2. DATE OF DEATH MONTH	DAY YEAR	3. TIME OF DEATH	
	70.11.0			-		DECEMBER	14 1995	3.00 A M	
	303 44 5500 4500	s. last birthday) YRS.	IF UNDER 1 Y		UNDER 24 HRS. URB MIN.	7. DATE OF BIRTH (Month, Day, Year)	8. BIF	THPLACE (State or Foreign intry)	
	181-44-5700 1X M 2 F 41 9a. FACILITY NAME (If not institution, give street and number)	THS.				NOV. 17		PA	
œ	HARBOR HOSPITAL		9b. CITY, TO		CATION OF D		9c. COUNTY OF	DEATH	
DIRECTOR	RESIDENCE OF DECEDENT			DAL	TIMOF	(E	n/a		
Ä	10a. STATE 10b. COUNTY	10c. CITY	TOWN OR	OCATION				10d. INSIDE CITY	
ā	MARYLAND	В	ROOK	LYN				LIMITS?	
AL	10e. STREET AND NUMBER			10f. ZIP	CODE		10g. CITIZEN O	WHAT COUNTRY?	
E	4115 AUDREY AVE. BROOKLY	N, MD	•	2	1225		U.S	. A .	
FUNERAL	11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S.	ARMED				NIC ORIGIN? (Specify Ye	na or No- 14. RA	CE — American Indian,	
BY F	1 Never Married 2 Married FORCES? 1 M YES 2 3 Wildowed 4 Divorced FFORCES? 1 M YES 2 IF YES, GIVE WAR OR DATES	_ NO			NO Specif	in, Puarto Rican, atc.)		eck, White, atc.	
	1973-1976			Λ				White	
ETED	(Specify only highest grade completed)	(Give kind of we	ork done duri	PATION ng most of	working	16b, KIND OF BU	JSINESS/INDUSTRY		
) LE	Elementary/Secondary (0-12) College (1-4 or 5 +)	ille. Do NOT use							
COMPL	17. FATHER'S NAME (First, Middle, Last)	RET	AILE					STORE	
				18.	MOTHER'S NA	ME (First, Middle, Malder	n Sumame)		
BE	HOWARD C. PATTERSON 19a. INFORMANT'S NAME (Type/Print)	444 444 444			SHIR	LEY RUNY	AN		
2						Route Number, City or Tox			
	DARLENE PATTERSON					BROOKLYN			
	1/A Burlet 2 Cremation 3 Ramoval from Stata Cemetery	CE AND DATE OF	er plecel				OCATION — City or		
- 1	21. SIGNATURE OF FUNERAL SERVICE LICENSEE	ENWOOL) MEI	1. PK	DDRESS OF FA	-16-95 L	OWER BU	JRRELL, PA.	
	101		S	ERL	ING A	SHTON FU	NERAL H	HOME, INC.	
	Mar D. Walter		7:	36 E	DMOND	SON AVE.	BALTO	MD. 21228	
	23. PART I. Enter the diseases, or complications that caused the abock, or heart failure. List only one cause on each i	desth. Do no	ot enter th	mode o	f dying, suc	h as cardiac or reap	piratory arrest,	Approximate	
	IMMEDIATE CAUSE (Final		0					Intarval Between Onset and Death	
	disease or condition								
	DUE TO (OR AS A CONSEQUENCE OF):								
8				TRES	YL 22	MOROME		1 MONTH	
CERTIFICATION	if any, leading to immediate	,		10.	D	CALL CA		15 1000	
E S	CAUSE (Disease or Injury that Initiated events	SECUENCE OF	(1,17)	ACU	IT N	ENAL FA	ILURE	45 clays	
Ē	reaulting in death) LAST	ocoochoc or,						7	
B	d								
A	PART II. Other aignificant conditions contributing to death but no	ot resulting in	the unda	riying car	use given in	Part I. 24s. WAS AP		Ib. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO	
MEDICAL	MESENTERIC THROMBOSIS, PHE	UMONI	A, CI	ROM	10	1 _ YES :	A	COMPLETION OF CAUSE OF DEATH?	
ME	ALCOHOLISM, HYPOXIC BRAIN I						^	1 YES 2 NO	
ä	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DI	EATH YES	□ NO	U	NCERTAI	1 IZ			
CIA	25. WAS CASE REFERRED TO MEDICAL 26. PI EXAMINER? HQSPITAL:	LACE OF DEATH		one)		1			
PHYSICIAN:	1 YES 2 NO 1 Inpatlant 2 ER/Outpatlant		OTHER: 4 - Nursing	Home 5	Rasidenca	8 Other (Specify)			
H	27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year)	28b. TIME INJU		WORK?	AT	28d. DESCRIBE HOW	INJURY OCCURED		
ВУ	1 Netural 5 Pending 2 Accident Investigation			YES	2 NO				
	3 Suicide 8 Could not be 28s. PLACE OF INJURY — At building, etc. (Specify)	t home, term, str	reet, factory,	offica		28t. LOCATION (Street City or Town, State	and Number or Rura	I Route Number,	
	4 Homicide detarmined					0., 0. 10, 0	,		
COMPLETED	29a. CERTIFIER (Check only 1 CERTIFYING PHYSICIAN: To the best of my knowledge,	, death occurred	at the time,	data and p	placa, and dua	to the cause(s) and ma	nner as stated.		
No.	one) 2 MEDICAL EXAMINER: On the basis of examination and/	or investigation,	, in my opini	on, death	occured at the	time, data and pieca, as	nd due to the cause	e(a) and menner as stated.	
	29b. SIGNATURE AND TITLE OF CERTIFIER				LICENSE NUN			D (Month, Day, Year)	
BE	holien Job . INTERN					1614-13			
임	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (I	ITEM 27) (Type, F	Print)	1 1	17	1017	DECEN	10er, 17 1113	
	MOBEEN IQBAL 3001 SOUTH H			ET HA	RBAR +	DSPITAL BA	ATIMAD =	MD 21125	
	31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE				>0:/ .	211174 01	TO WEE	- W	
	DEC 1 5 1995 Jali Skurdean Rardall								

fal-transit permit. Pages 1, 2, 3 should ther death. Page 6 may be retained by the hospital or attending physician. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physicians.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burn	ath with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.
R ATTENDING PHYSICIAN: The law requires the	RECTOR: After this certificate has been signed	urs after death with the State Dept. of Health	m 28 is marked, or item 23 shows a
TO THE HOSPITAL OF	TO THE FUNERAL DIF	be filed within 72 hou	IMPORTANT: If Ite

5 1995°

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White
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21401 Approximate
Interval Between Onset and Death
ERE AUTOPSY FINDINGS
MAILABLE PRIOR TO OMPLETION OF CAUSE
WAILABLE PRIOR TO OMPLETION OF CAUSE F DEATH?
MULABLE PRIOR TO OMPLETION OF CAUSE F DEATH? YES 2 NO
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TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within a company of the management of the property of the property of the conficuence of the attention physician and company in the Fill of the conficuency of the conficuency of the property of the conficuency of the conf

TO BE COMPLETED BY FUNERAL DIRECTOR

FOR 1 STATE REGISTRAR	STATE OF MARY		RTMENT OF H		MENTAL	HYGIENE REG. NO.			
1. DECEDENT'S NAME (First, Mic	idle, Last)			2. DATE OF DEATH 3. TIME OF DEATN					
BESSIE	- PITTI		DE	6071	9		57AH		
4. SOCIAL SECURITY NUMBER		83 YRS.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE O			RTNPLACE (State	or Foreign
213-62-4404	1 🗆 M 2 💢 F	Moone Mine.	JUN	.5,1912	= Vi	irginia			
Be. FACILITY NAME (If not institu				OR LOCATION OF DE	EATH	90	COUNTY O		
Bon Secour H			Balti	more			N/	A	
	b. COUNTY	10c. CIT	Y, TOWN OR LOCAT	NON				10d, INSIDE	CITY
Maryland	N/A	Ba	ltimore					1 X YES	
10e. STREET AND NUMBER		,	10	. ZIP CODE		10	g. CITIZEN (OF WHAT COUNT	TRY?
1217 W. Faye	tte Street			21223			U.S.	A.	
1 Never Married 2 Married IE VEC CIVE MAD OR DATES								Black, While, etc.	
15, DECEDE	NT'S EDUCATION	16a, DECEDENT'S	USUAL OCCUPATION	ON	16b.	KIND OF BUSINE	SS/INDUSTE	TY .	
Elementary/Secondary (0-12)	college (1-4 or 5+)	life. Do NOT u	work done during mo ise retired.)	ist or working					
11th	_	Hou	swife			Own Hom	e		
17. FATHER'S NAME (First, Middle				16. MOTHER'S NA		liddle, Maiden Surr	eme)		
Johnny Hick				Alease					
19a. INFORMANT'S NAME (Type) Horace L. P				ind Number or Aural treet Un					28390
20a, METNOD OF DISPOSITION		20b. PLACE AND DATE	OF DISPOSITION (N		DATE			or Town, State	VA III A
4 🗆 Donatton, 5 🗆 Other (To	eofy)	Mt. Zion	Cemeter			Lanso	downe	Maryla	and
21. SIGNATION OF FORERAL S	ENVICENSES		March	Funeral	Home	East			
*XO VIDIA	1 / VIA UNE AF	Y FUI	1101	E. North	Aven	ue, Bal	timor	e, MD 2	21202
	asea, or complications that cau		not enter the mo	ode of dying, suc	h as card	lac or respirate	ory arrest,		roximata
immediate cause (Final	t failure. List only one cause or	n each line.							val Between et and Death
disease or condition resulting in death)	a. CAPLDI	AC A	RRHY	THMI	4				
Sequentially list condition	DUE TO (OR A	ME	D150	e DER					
if any, leading to immedia cause. Entar UNDERLYING	10		mor						
CAUSE (Disease or injury that initiated events	c 01011/1	AS A CONSEQUENCE C							
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DART II. On a sales Maria					A I				
	conditions contributing to deat	CONTR			Part I.	PERFORME		24b. WERE AUTO AVAILABLE	PRIOR TO
escuerco	, -	001172	normal		_	1 TES 2	NO	OF DEATH?	
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25, WAS CASE REFERRED TO N	CONTRIBUTE TO CAUSE		ATN (Check only one)		иП				
EXAMINER?	HOSPITAL:		OTHER:						
27. MANNER OF DEATH	28a. DATE OF INJUI	RY 28b. TII	ME OF 28c, IN	ne 5 Residence	_	CRIBE HOW INJU	RY OCCURE	ED .	
1 Netural 5 Per	(Month, Day, Yes	nr) IN		YES 2 NO	11000				
2 Accident		URY — At home, farm,	street, factory, offic	ce	281. LOC	ATION (Street and	Number or R	ural Route Numbe	ν,
	ermined	эрвспу)			City	or Town, State)			
(Crieck Orny	VINO PNYSICIAN: To the best of my kr L EXAMINER: On the bests of examin							(a) and man	
		and and meanight	ion, in thy opinion,						
296. SIGNATURE AND TITLE OF	CENTIFIER			29c. LICENSE NU	MBER) → →	29	M. DATE SIG	GNED (Month, Day	(Year)
30, NAME AND ADDRESS OF P	ERSON WNO COMPLETED CAUSE OF	DEATH (ITEM 27) /Xm	e Print)	130	-1			12/12/	91
BON SEC	ours Hospi	TAL	BALI	mores	F	mp 9	T	S. Mil	ler
DEC 1 5 199	F 11. 4 . 0)			
PEOT 9 133	5 sal Burden Re	whalf						Di	HMH-16 Rev 1/89

A SOCIAL SECURITY NUMBER 212-07-9963 1 M x 2 F 89 YMS. 89 YMS. 89 YMS. 80 SUTTON DOING BE NOW! 80 YMS. 80 COTTEND OF DEATH 80 YMS. 80 YMS. 80 YMS. 80 COTTEND OF DEATH 80 YMS. 80 YMS. 80 YMS. 80 COTTEND OF DEATH 80 YMS. 80 YMS. 80 COTTEND OF DEATH 80 COTTEND OF DEATH 80 YMS. 80 YMS. 80 YMS. 80 COTTEND OF DEATH 80 YMS. 80 YMS. 80 COTTEND OF DEATH 80 COTTEND OF DEATH 80 COTTEND OF DEATH 80 COTTEND OF DEATH 80 COTTEND OF DEATH 80 COTTEND OF DEATH 80 COTTEND OF DEATH 80 COTTEND OF DEATH 80 COTTEND OF DEATH 80 COTTEND OF DEATH 80 COTTEND OF DEATH 80 COTTEND OF DEATH 80 COTTEND OF DEATH 80 COTTEND OF DEATH 80 COTTEND OF DEATH 80 COTTEND OF DEATH 80 COTTEND OF DEATH 80 COTTEND OF DEATH 80 COTTEND OF DEATH		1. DECEDENT'S NAME GILMO Linwood — Cilmour	RE Rohe	er					pate of Death Becember 1	1. 1995	3. TIME OF DEATH 11:45 A	
South Sout		4. SOCIAL SECURITY NUMBER 212-07-9963	5. SEX 1 X M 2 F	B. AGE (In yrs. I				R 24 HRS. 7.	DATE OF BIRTH	8. B	RTHPLACE (State or Foreign	
The street and Number 15706 Greenspring Ave. 17. Martial Status 11. Martial Status 12. Martial 17. Was December even in U.S. Asmed Professor 1 ves 2 (2/Mo 17. Was December 19. Martial 19. Nover Martial 2. Martial 17. Was December 19. Nover Martial 2. Martial 17. Was December 19. Nover Martial 2. Martial 17. Was December 19. Nover Martial 2. Martial 17. Was December 19. Nover Martial 2. Martial 17. Was December 19. Nover Martial 2. Martial 17. Was December 19. Nover Martial 2. Martial 17. Was December 19. Nover Martial 2. Martial 19. Nover Wash on Date 19. Ves 2. (Molecule 19. Ves 2. (M	TOR	5706 Greenspring Ave Baltimore N/A										
United States Control	_	Maryland N/A			10c. CIT						10d. INSIDE CITY LIMITS? 1 X YES 2 NO	
Secondary Seco	NERAL	5706 Greenspring					2120	09		United		
Sementary/Secondary (P-12) College (1-4 or 5 +) 2 years Gen. Mgr. State Use Ind. MD State Penitentiary	ΒX	1 Never Married 2 Married	FORCES? 1	YES 2	(NO	NO If yes, specify Cuban, Maxican, Puerto Rican, etc.) Black					Black, White, atc.	
Sen Jamilian Rother Salte Rother Salte Salte Rother Salte Rother Salte Salte Rother Salte Salte Rother Salte	ᇤᅵ	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4 or 5+)		(Give kind of life. Do NOT u	work done during se retired.)	g most of world					
180. MALINA ADDRESS (Singer and Number or Rural Riches Number, City or Sens. 250. Code) 180. MALINA ADDRESS (Singer and Number or Rural Riches Number, City or Sens. 250. Sens. 250. Code) 180. MALINA ADDRESS (Singer and Number or Rural Riches Number, City or Sens. 250. Sens. 250. Code) 180. MALINA ADDRESS (Singer and Number or Rural Riches Number, City or Sens. 250. Sens. 250	BE	17. FATHER'S NAME (First, Middle, Last)	HER'S NAME	(First, Middle, Maiden								
21. SIGNATURE OF FUNERAL SERVICE LICENSEE JOHN O. Mitchell IV 22. NAME AND ADDRESS OF FACILITY JI CC'Rell-Wiedereld Home, Inc. 6500 York Rd. 112. SIGNATURE OF FUNERAL SERVICE LICENSEE JOHN O. Mitchell IV 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arreat, shock, or heart failure. Liet only one cause on each line. IMMEDIATE CAUSE (Finel diseases or condition resulting in deeth) DUE, TO (OR AS ACONSEQUENCE OF): PULL MUNCH CAUSE (Disease or injury that inflitted evenits resulting in deeth) LAST DUE TO (OR AS A CONSEQUENCE OF): A. DUE		Steven Luers	196. MAILING 51 No:	ADDRESS (Sin	eet and Numbe l Dr.	r or Rural Rout Timor	nium, MD	21093				
23. BAST I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert failure. Liet only one ceuse on each line. IMMEDIATE CAUSE (Finel disease or condition resulting in deeth)		1 to Burial 2 Cremation 3 Ren 4 Donation 5 Other (Specify)				dge Cen	netery		114		r Town, State	
23. BAST I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert failure. Liet only one ceuse on each line. IMMEDIATE CAUSE (Finel disease or condition resulting in deeth)		John O. Mitc	hell IV	T		14i to	chell- York	Wieder Rd La	eld Home	, Inc.		
PART ii. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part i. 248. WAS AN AUTOPSY PROFORMED? 1 YES 2 MO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO OTHER: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Presidence 8 Other (Specify) 27. MANNER OF DEATH 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Presidence 8 Other (Specify) 288. DATE OF INJURY (Month. Day, Year) 1 YES 2 NO OTHER: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Presidence 8 Other (Specify) 280. DATE OF INJURY WORK? 1 YES 2 NO OTHER: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Presidence 8 Other (Specify)	z	ahock, or heert fallure. IMMEDIATE CAUSE (Finel disease or condition	e. DUE 1TO (on each ile	lush seouence				a carolac or reap	eratory arreat,	intarvei Bets	
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T Natural 5 Pending 2 Accident Investigation M t YES 2 NO	YSICIAN: ME	25. WAS CASE REFERRED TO MEDICAL EXAMINER? D.L./ HOSPITAL: OTHER:										
		27. MANNER OF DEATH 1								D		
29a. CERTIFIER	O BE COMPLE	(Check only	ER: On the beals of axi				on, death occu	ured at the tim	ne, date and placa, a	nd due to the car		
(Check only one) 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(a) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(a) and manner as stated.	0	The second secon	7.8	-			250.00	PENSE HOMBE	in .	290, DATE STO	MED (MONTH, Day, 1987)	

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D	PITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after de	100 NOCOTOD After this confidence has been signed by the standard and confidence of the signed and confidence of the standard
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DIVISION OF VITAL RECORDS, P.O. BOX 88/60	Ö	S.
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		1 - FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPAR	RTMENT OF H	EALTH AND	MENTAL HYGIE		- ,		
		1. DECEDENT'S NAME (First, Middle, Last) John	Carroll Su	llivan			2. DATE OF DEATH MONTH	DAY YEAR	3. TIME OF DEATH		
		4. SOCIAL SECURITY NUMBER		(In yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)	2, 1995	9:35P M		
pinous		144-01-3375 9a. FACILITY NAME (If not institution, give st	¹\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	YRS.	MONTHS DAYS	HOURS MIN.	November 12	1914 N	Maryland		
. 2, 3 sho	DIRECTOR	9a. FACILITY NAME (If not Institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH N/a RESIDENCE OF DECEMENT									
Pages 1	REC	10a. STATE 10b. COUNTY		10c. CIT	Y, TOWN OR LOCAT	TION			10d. INSIDE CITY		
permit. P		Maryland N/	Α		Baltin				1) YES 2 NO		
nsit pe	FUNERAL	1502 East Cold	Spring Lane		101	21218		10g. CITIZEN O	F WHAT COUNTRY?		
DZO physician. burial-transit	FUN	11. MARITAL STATUS 1 Never Married XXX Merried	12. WAS DECEDENT EVER II	N U.S. ARMEO	13. WAS DEC	ENDENT OF HISPA	NIC ORIGIN? (Specify Year, Puerto Rican, etc.)	es or No- 14. R/	ACE — American Indian, lack, White, etc.		
	BY	3 Wildowed 4 Divorced	FORCES? VIVYES	ATES WWII	1 TYES	XXXO Speci			White		
r attending use as the	TED	15. DECEDENT'S EDUC (Specify only highest grade of		16a. DECEDENT'S	USUAL OCCUPATION	ON ast of working		USINESS/INDUSTRY	7		
. 0 -	COMPLET	Elementary/Secondary (0-12)	College (1-4 or 5+) 5+	iiie. Do NOT u				Educatio Governm	n Welfare		
the hospital detached for	MOX	17. FATHER'S NAME (First, Middle, Last)		Lawye		lent					
2 2 E	BE (John Carroll Sul	livan				Turner				
retained 5 should notified	2	19a. INFORMANT'S NAME (Type/Print) A.W. Sullivan					Route Number, City or To		aryland 21218		
may be		20a METHOD OF DISPOSITION 1 Neuriel 2 Cremetion 3 Ramo	20b	PLACEANDDATE	OF DISPOSITION (No	ime of		OCATION — City or			
Page 6 ma I director, p		4 Donation 5 Other (Specify)	I S	t Mary S				ltimore,	Maryland		
ter death. Page 6 m the funeral director, oval.		Some Oles	Analkon.	a hi			itchell-Wi				
B TE S	- 1	23. PART I. Enter the diseases or co	omplications that caused	the death. Do i	6500	York Roa	ad Baltimo	re, Mary	land 21212		
4 E E S		shock, or heert fallure. L IMMEDIATE CAUSE (Final disease or condition	ist offly one cause on e	hao le				Depart Speed	Interval Between Onset and Death		
within npleteh crema	NO	resulting in death)		CONSEQUENCE O		- Cen	<u> </u>		12/12/1995		
executed and con burial.		Sequentially list conditions,	C ,			(•	1991.		
sician rior to	CATIO	f any, leading to immediate cause. Enter UNDERLYING									
nding phy Hygiene p	Ē	CAUSE (Disease or Injury that initiated events resulting in death) LAST	DUE TO (OR AS A	CONSEQUENCE O	3.504	1 . 0			198776		
T HE BE	CERT	d				1 /			1130		
at the dea by the att and Menta y Injury,		PART II. Other significant conditions	contributing to deeth b	ut not resulting	In the underlying	cause given in	Part I. 24s. WAS AI PERFO	N AUTOPSY 2	4b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO		
requires that the seen signed by to thealth and shows any in	MEDIC						1 _ YES	2 NO	COMPLETION OF CAUSE OF DEATH?		
S. of		DID TOBACCO USE CONTR	IBUTE TO CAUSE O	F DEATH YE	S NO C	UNCERTAL	NØ		1 TYES 2 NO		
E se E	SICIAN:		HOSPITAL:	26. PLACE OF DEA	OTHER:						
rSician: The certificate the the State	ÌÈ	1 VES 2 NO 27. MANNER OF DEATH	1 Inpatient 2 ER/Outp	28b. TIM	E OF 28c. INJ	URY AT	8 Other (Specify) 28d. DESCRIBE HOW	INJURY OCCURED			
DING PHYS After this of death with	ВУ Р	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)		M 1 🗆 Y	RK? 'ES 2 NO					
TTENDI CTDR: A after d	0.	3 Suicide 6 Could not be determined	28a. PLACE OF INJURY building, atc. (Spec	— At home, ferm, (cify)	street, fectory, offici		28f. LOCATION (Street City or Town, State		al Route Number,		
4 12 -	APLETI		IAN: To the treat of my knowl								
HOSPITAL FUNERAL Within 72 TANT: If	COM	2 MEDICAL EXAMINER	On the beals of examination	ind/or investigation	n, in my opinion, d				e(a) and menner as stated.		
TO THE HOSPITA TO THE FUNERA De filed within 73	BE	296. SIGNATURE AND TITLE OF CERTIFIER	200	W 7.		D226			ED (Month, Day, Year)		
FFA	유	30. NAME AND ADDRESS OF PERSON WHO									
	- -	Subramanian 31. DATE-SHEDH Manth. Day. Yeard _	Srinivas 56	01 Loch	Raven Bl	vd Balti	more, Mary	/land 21	239		
		31. DATE DEC 1 5 1995	en alludiar le	work.							

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4YSICIAN: The law requires that the death certificate be executed within the trous after death. Page 6 may be retained by the hospital or attending physician.	this certificate has been signed by the attending physician and compared lines for the function page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should not the State Dept. of Health and Mental Hydiene prior to burial, committee, or removed.	arked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and can be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burill.	IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic e

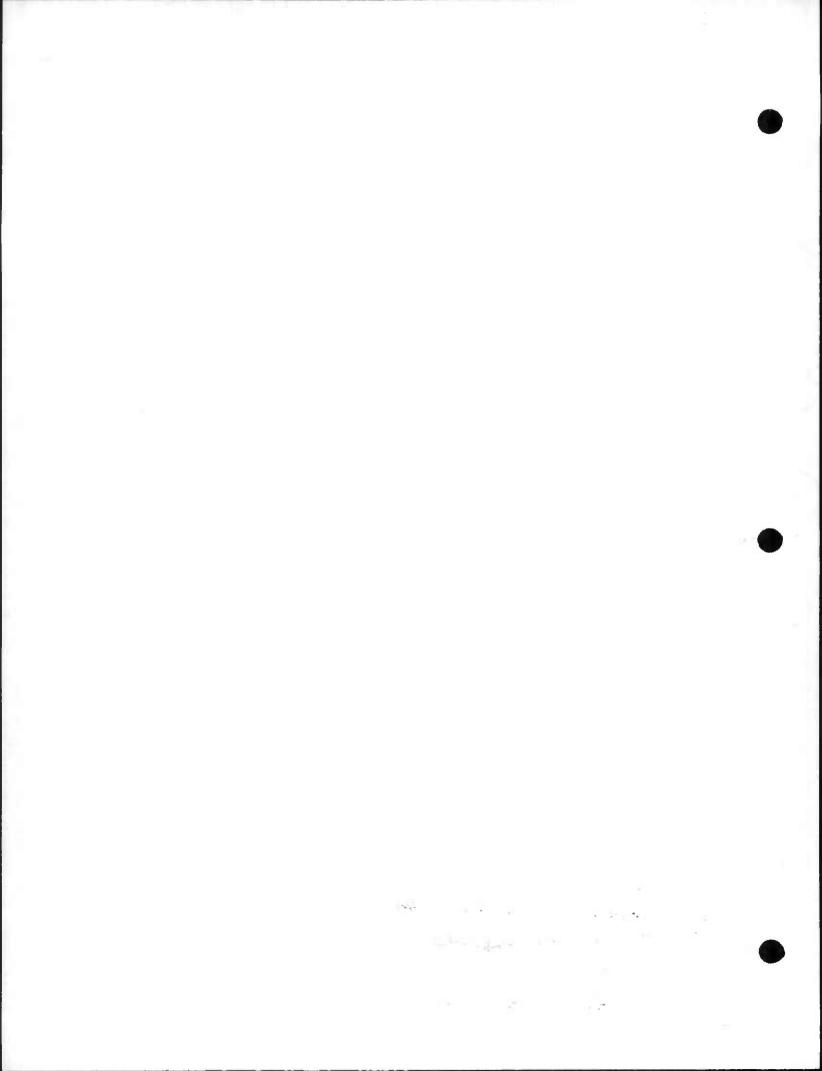
											95	30	5034		
	1 - FOR STATE REGISTRAR	STATE OF N	MARYLAND A	DEPAR	RTMEN	T OF H	EALTH DEAT	AND #	MENTA	L HYGIEN	E				
	1. DECEDENT'S NAME (First, Middle, Last)							OF OEATH			3. TIME OF DEATH				
	Melba Sc	nderegge	r						Dec.		19	995	9:00 A M		
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. la	st birthday)		R 1 YEAR	IF UNDER		7. DATE	OF BIRTH		8. BIRTH	PLACE (State or Foreign		
	219-78-6490	1 □ M 2 ¬F	80	YRS.	MONTHS	DAYS	NOURS	MIN.		n, Day, Ybar) uary 16.	1019	Country			
	Se. FACILITY NAME (If not Institution, give at	reet and number)	- 00		9b. CIT	Y, TOWN C	R LOCATION	ON OF DE	ATH	ualy 10.	9c. COU	NTY OF D	Y J CILICI EATH		
HC HC	3021 Southview Road				El	licot	t Cit	v			Ho	ward			
5	RESIDENCE OF DECEDENT			,							110	WCZE C			
DIRECTOR	Maryland Hot		10c. CIT		OR LOCAT						10d. INSIDE CITY LIMITS?				
9		ward		<u> </u>	EII		City						1 YES 2 X NO		
FUNERAL	3021 Southview Road					101	. ZIP CODE				- 17		VHAT COUNTRY?		
<u>H</u>								21042			U.S	.A.			
5	11. MARITAL STATUS 1 Never Married 2 Married	12. WAS DECEDEN FORCES? 1	T EVER IN U.S. AF		13.	WAS OEC	ENDENT C	F HISPAN	IC ORIGIN	17 (Specify Yes Ricen, etc.)	or No-	14. RACE Black	— American Indian, c, White, atc.		
B	3 Widowed 4 Divorced	IF YES, GIVE W					2 X NO			mount, oter,		Spech	by:		
	15. DECEDENT'S EDUC	2471011	1.00				271						White		
#	(Specify only highest grade	completed)	16a. Di	ECEDENT'S Give kind of a. Do NOT u	work done	during mo	DN st of workin	g	16b	KIND OF BUS	HNESS/INC	USTRY			
COMPLETED	Elementary/Secondary (0-12)	College (1-4 or 5 d	,	ir Sty					ш	air Salo					
<u></u>	17. FATHER'S NAME (First, Middle, Last)		12.13	u ocy	TISC										
ö	Louis M. Biedermann	1								Middle, Maiden	Sumame)				
LOUIS M. Bledermann Mary C. Bass 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ACCRESS (Street and Number or Rural Route Number, City or Number)															
임	John Sonderegger									ity, Mar			n		
			20b. PLACE					ши							
	20a, METHOD OF DISPOSITION 1 \(\tilde{\text{L}}\) Burlai 2 \(\text{Cremation} 3 \) Ramo 4 \(\text{Donation} \) Donation 5 \(\text{Dother}\) Other (Specify)	ovel from State	cemetery, cre	ematory or o	ther place	1		4.5	1		CATION —				
H. BIGHATURE OF PUNETAL SERVICE LIGENSEE 12. NAME AND ADDRESS OF FACILITY Leroy M. & Russell C. Witzke Funeral Homes								ryland							
								nes							
	Leonerace		0		1	630 E	dmonds	son Av	venue	Catons	ville	, Mary	yland 21228		
	23. PART I. Enjor the diseases, or c shock, or heart failure. I	omplications the	caused the de	eath. Do i	not ente	r the mo	de of dyl	ng, auch	ss card	diac or reaple	ratory srr	eat,	Approximata		
	IMMEDIATE CAUSE (Final								_				Interval Between Onset and Death		
	disease or condition resulting in death)	uneta	stati	tatic endometrial a					Carcinoma			12 months			
			OR AS A CONSE												
Z	Samuellally that and this are														
ERTIFICATION	Sequentially list conditions, if any, leading to immediate	OUE TO	OR AS A CONSE	OUENCE O	F):										
2	cause. Enter UNDERLYING CAUSE (Disease or Injury														
#	that initiated events resulting in death) LAST	OUE TO	(OR AS A CONSE	OUENCE O	F):										
		l													
PART II. Other significent conditions contributing to deeth but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY									WERE AUTOPSY FINDINGS						
S	PERFORMED? AMALA								AVAILABLE PRIOR TO COMPLETION OF CAUSE						
	1 U YES 2 DE NO OF DEATH?									OF DEATH?					
PHYSICIAN: MEDICAL	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO WINCERTAIN														
NA I	25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF GEATH (Check only one)														
S	EXAMINER? 1 VES 2 NO 1 Inpetiant 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify)														
¥	27. MANNER OF DEATH	28s. DATE OF		28b. TIM	-	28c. INJ	<u> </u>	sidence 1							
	1 Natural 5 Pending	(Month., D.	ly, Your)		URY		RK?	1 100	28d. DESCRIBE HOW INJURY OCCURED						
2 Accident investigation 3 Suicide 8 Could not be detarmined detarmined detarmined							. 0								
							oute Number,								
	29a. CERTIFIER														
COMPLET	(Check only														
8	2 MEOICAL EXAMINER	. On the basis of a	emination and/or	investigatio	n, in my	opinion, de	eath occur	ed at the I	time, data	and place, and	dus to th	e cause(a)	and menner as stated.		
BE	296. SIGNATURE AND TITLE OF CERTIFIER		1				-	NSE NUM	and the		29d. DATE	SIGNED	(Mgnth, Day, Ybar)		
2	Ung 16 17 M),				1) 4	113	9.		P 1;	2/13	195		
·	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUS	E OF DEATH ATE	M 273 /Kma	Deimt)				-0						

ON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

32 REGISTRAR'S SIGNATURE

DEC 1 5 1995

	1 - STATE REGISTRAR	STATE OF			RTMENT OF I			MENTAL HYGIEN			0033
	1. OECEOENT'S NAME (First, Middle,	Lest)		Sn	nith			2. DATE OF DEATH DOC	47	YEAR 3.	TIME OF DEATH
	4. SOCIAL SECURITY NUMBER 5. SEX 8. AGE (In yrs. last birthday) F UNDER 1 YEAR F UNDER 24 HRS. 7. DATE OF BIRTH 8. B									Country)	ACE (State or Foreign
	9e. FACILITY NAME (If not institution,		1 04	1110.	9b. CITY, TOWN	OR LOCATI	ON OF DE		9c. COUNT		
e e	Joseph Ritch	_			Ba1	timo	ore		N/I	A	
DIRECTOR	RESIDENCE OF DECEDEN 10a. STATE tob. CC			10c, CI7	Y, TOWN OR LOCA	TION				10	d. INSIDE CITY
	Md. N/A Baltimore										LIMITS? X YES 2 NO
FUNERAL	100. STREET AND NUMBER 2224 East Oliver Street 21213 U.S.A.									T COUNTRY?	
NS S	tt. MARITAL STATUS	12. WAS DECED	NT EVER IN U.S.	ARMEO	13. WAS DE	ENOENT (OF HISPAN	IIC ORIGIN? (Specify Ye	U.S		American Indian.
B	1 Never Married 2 Married 3XXWIdowed 4 Divorced	IF YES, GIVE	1 YES 2 WAR OR DATES	∑ио	RMEO NO 13. WAS DECEMOENT OF HISPANIC ORIGIN? (Specify Yee or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 — YES 2 N NO Specify: Black						
TE	15. DECEOENT'S (Specify only highest	grade completed)			Work done during me		ng	16b. KIND OF BU	SINESS/INDU	STRY	
COMPLETED	8th	Elementary/secondary (U-12) College (1-4 of 5 +)						Own H	ome		
Ö	17. FATHER'S NAME (First, Middle, Las Foye Feemste					16. MOT	HER'S NA	ME (First, Middle, Meiden			
BE	190. INFORMANT'S NAME (Type/Print)			19h MAII INC	AODRESS (Street	and Number	or Brazal 6		1 war	_	
٥	196. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carolyn Cooper 1712 Forster St., Harrisburg, Pa. 1										17103
	20e. METHOD OF DISPOSITION 1 Burlel 2 Cremation 3	Ramoval from State	comptony	CE AND DATE	OF DISPOSITION (N	ame of		OATE 20c. LO	CATION — CI	ty or Town,	State
	4 ☐ Donation 6 ☐ Other (Specify) 21. SIGNATURE The Full First Full From First Full From First Full From First Full From First Full From First Full From First Full Full From First Full Full Full Full Full Full Full Ful		_ Che	sapea	ake Cre	mato	ory	12-13-95	Belt		11e,Md. 21222
TO BE COM	21. SIGNATURE OF FUNERAL SERVICE LICENSE 22. NAME AND ADDRESS OF FACILITY Bradley-Ashton Funeral Home, 2134 Willow Spring Rd., Balto							, Inc.			
	ahock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final Onset and									Approximate interval Between Onset and Death	
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated eventa resulting in death) LAST A										
MEDICAL C	OF DEATH?								MPLETION OF CAUSE		
Z.	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN										
SICL	25. WAS CASE REFERRED TO MEDICAL EXAMINER? t YES 2 NO							11 - 2			
PHYSICIAN:	27. MANNER OF DEATH	28e. DATE (26b. TIM	E OF 28c. IN.	URY AT	rsidence	28d. DESCRIBE HOW I	NJURY OCCU	REOV	Haspic
B	2 Accident Investige	26e PLACE				M 1 YES 2 NO					Al and
ETED	3 Suicide 6 Could not be 4 Homicide 6 Could not be determined 26e. PLACE OF INJURY — At home, farm, street, fectory, office building, etc. (Specify) 28f. LOCATION (Street end Number or Rural Route City or Town, State)							Number,			
COMPLE								to the cause(e) end mer			d manner ee stated.
BE C	29b. SIONATURE AND TITLE OF CER	TIFIER 2	_			29c. LICI	ENSE NUM	BER	29d, DATE S	SIONEO (Mo	nth, Day, Year)
5	30. NAME AND ADDRESS OF PERSO	WHO COMPLETED CA	USE OF DEATH (TEM 27) (7000	. Print)	0	136	006	13	De	280
	31. OATE FILED (Month, Day, Year)	14. Po	AR'S SIGNATURE	10		R	eac	(St.	Bal	to:	21201
- 8	DEC 1 5 1995	juin stiwales	charlett								



DIVISION OF VITAL RECORDS, P.O. BOX 68760

Pages 1, 2, 3 should

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 -CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH 3. TIME OF DEATH YEAR PASOUALINA SCARFIELD Dec 1995 10:55 AM 4. SOCIAL SECURITY NUMBER 7. DATE OF BIRTH (Month, Day, Year) 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign 94 219-32-3019 1 □ M 2 X F Jan 25,1901 Italy 9a. FACILITY NAME (If not institution, give street and number, 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Johns Hopkins Geriatric Center Baltimore N/A RESIDENCE OF DECEDENT toc. CITY, TOWN OR LOCATION 10b. COUNTY tod. INSIDE CITY Maryland N/A Baltimore 1 X YES 2 | NO toe. STREET AND NUMBER FUNERAL tot ZIR CODE tog. CITIZEN OF WHAT COUNTRY? 6700 O'Donnell Street 21224 USA t2. WAS DECEDENT EVER IN U.S. ARMED FORCES? t ☐ YES 2 X NO IF YES, GIVE WAR OR DATES t3. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No-14. RACE — American Indian, Black, Whita, atc. If yes, specify Cuban, Maxican, Puerto Rican, atc.)

1 YES 2 NO Specify: t Never Married 2 Married BY 3 X Widowed 4 Divorced White ETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION t6b. KIND OF BUSINESS/INDUSTRY (Specify only high (Give kind of work done life. Do NOT use retired.) Elementary/Secondery (0-t2) College (1-4 or 5+) COMPL Homemaker 6 Own Home t7. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) James Coppola Unknown BE 19a, INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, Steta, Zip Code) 2 John Scarfield 6700 O'Donnell St. Baltimore, Md 21224 METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State t X Burial 2 Cremation 3 Remo Stanislaus Cem. Donation 5 - Other (Specify) 12-15 Baltimore, Md. 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Connelly Funeral Home of Dundalk 7110 Sollers Point Rd 23. PART I. Enter the discusses, or complications that caused the death shock, or heavifellure. List only one cause on each line. Interval Between **Onset and Death IMMEDIATE CAUSE (Final** disease or condition Aspiration pneumonia reaulting in death) Year DUE TO (OR AS A CONSEQUENCE OF) ⊾ Dementia CERTIFICATION 1 Year Sequentially list conditiona, DUE TO (OR AS A CONSEQUENCE OF) If any, leading to immediate cause. Enter UNDERLYING CAUSE (Diseese or Injury DUE TO (OR AS A CONSEQUENCE OF) that initiated events reaulting in death) LAST PART II. Other algnificent conditions contributing to death but not resulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS MEDICAL AMILABLE PRIOR TO Severe malnutrition, gastric ulcer, ostepor-COMPLETION OF CAUSE 1 TYES 2 X NO osis, atrial fib., hypoglycemia 1 TYES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES IN NO IN UNCERTAIN I PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE DF DEATH (Check only one) EXAMINER? HOSPITAL: OTHER:
4X Nursing Home 5 - Residence 6 - Other (Specify) ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 X Natural 5 Pending 1 YES 2 NO ВУ 2 Accident 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 28e. PLACE OF INJURY - At home, term, street, fectory, office 3 Suicide 8 Could not be determined COMPLETED 4 Homicide 29a. CERTIFIER 1 IX CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(e) end manner ee stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIE 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE whil

D46360

un

CAUSE OF DEATH (ITEM 27) (Type, Print)

NKROMMI

32. REGISTRAR'S SIGNATURE

DHMH-16 Rev 1/89

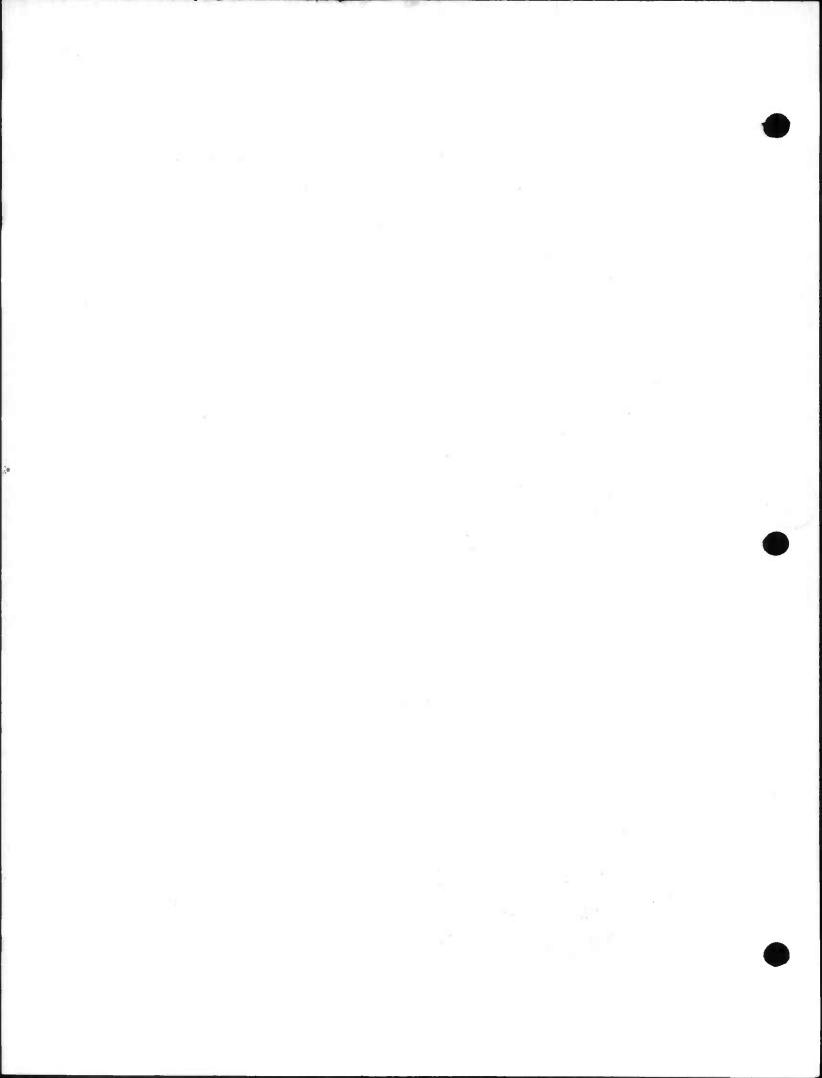
12/12/95



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30. HAME AND ADDRESS OF PERSON

DEC 1 5 1995



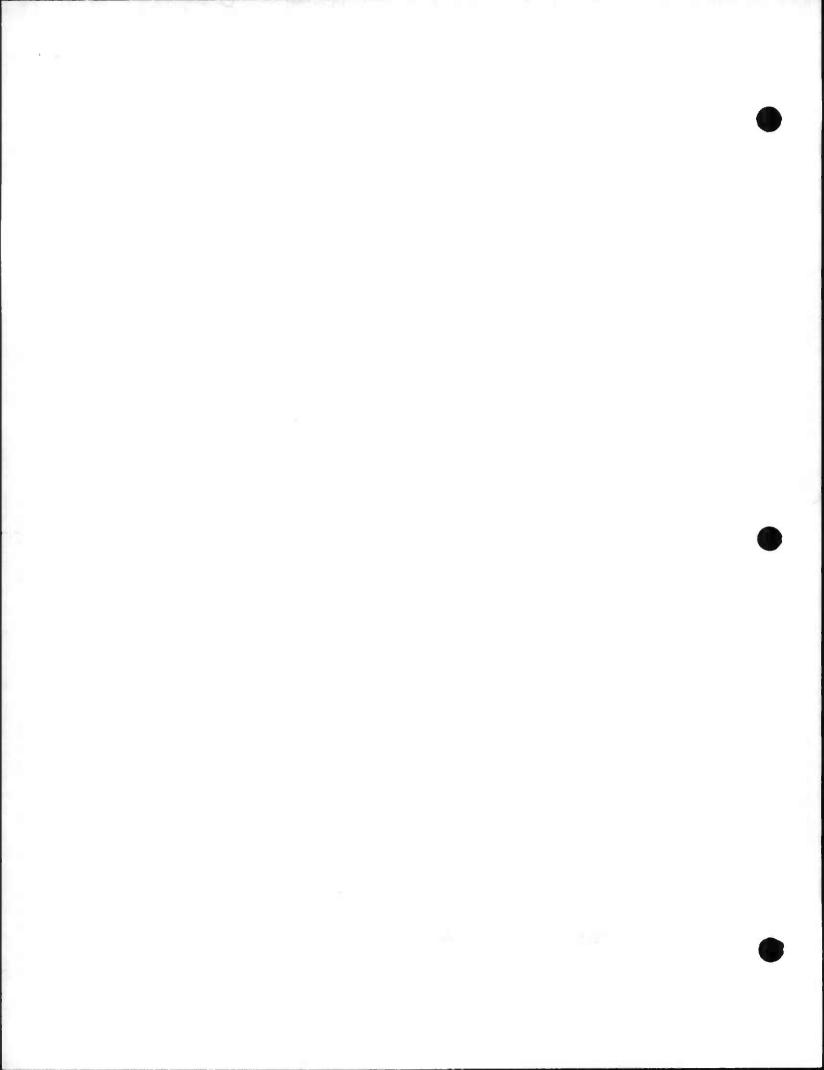
X 68760 BALTIMORE, MARYLAND 21215-0020	L DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours.	DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should
DIVISION OF VITAL RECORDS, P.O. BOX 68760	1. The law requires that the death certificate be executed within 24 hours	cate has been signed by the attending physician and completely filled in by the
DIVISION OF VI	. DR ATTENDING PHYSICIAN	DIRECTOR. After this certific

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 noun series. Page 6 may be retained by the hoss TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detache be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If them 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL	HYGIENE
CERTIFICATE OF DEATH	REG. NO.

	1 - FOR STATE REGISTRAR	E OF MARYLAND /		MENT OF H		MENTAL HYGIENI REG. NO.	E				
	1. OECEDENT'S NAME (First, Middle, Last)			2. DATE OF DEATN	3. TIME OF DEATH						
	GERALDINE	SMITH				December		95 10:40 PM			
	4. SOCIAL SECURITY NUMBER 5. SEX	6. AGE (In yrs. Inc		F UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH	8.	BIRTHPLACE (State or Foreign			
	212-56-4367 1□ м	13	YRS.	IONTHS DAYS	HOURS MIN.	Jul. 31,		Country) /irginia			
	9a. FACILITY NAME (If not institution, give street and no	imber)		b. CITY, TOWN C	R LOCATION OF D		9c. COUNTY				
O	Bayview Hospital			Balt	imore		N/	'A			
DIRECTOR	RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY		10c. CITY	TOWN OR LOCAT	ION			10d. INSIDE CITY			
DIR	Maryland N/A			ltimore				LIMITS?			
	10e. STREET AND NUMBER		1 20		ZIP CODE		10g, CITIZEN	1 X YES 2 NO			
ER/	812 N. Woodington Roa		S.A.								
FUNERAL	11. MARITAL STATUS 12. WAS	21229 ARMED 13. WAS DECEMBENT OF HISPAI			NIC ORIGIN? (Specify Yes		RACE — American Indian.				
ВУ F	1 X Never Married 2 Married FORC	NO	If yes, sp		nn, Puerto Rican, atc.)		Black, White, etc. Specify:				
					23		Black				
COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed)	(G	live kind of wo	SUAL OCCUPATION No. of the done during mo	N st of working	16b. KIND OF BUS	INESS/INDUST	TRY			
Z.	Elementary/Secondary (0-12) College	(1-4 or 5+)	Do NOT use	,		variou	is tr	ades			
ME	17. FATHER'S NAME (First, Middle, Last)		Labor	er				ades			
	Raymond Smith					AME (First, Middle, Meiden	Surname)				
BE	19a. INFORMANT'S NAME (Type/Print)	19	h MAILINO A	DDRESS /Street o		Lemon Route Number, City or Town	State Tie Co.	4.1			
2	Juanita Patterson										
	20a. METNOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of OATE 20c. LOCATION — City or Town, State										
	1 X Burtal 2 Cramation 3 Removal from 4 Donation 6 Sphir (Specify)	Arbut	matory or other	norial	Park	12/15 Ar					
	21. SIGNATURE OF PUNERAL SERVICE LICENSEE	//	110	22. NAME AN	D ADDRESS OF FA	CILITY	Ducus,	Harytana			
	1/60/11 P	Mis.	()			Home East					
	23. PART/1. Enter/the diseases, or complicat	ions that caused the de	ath Do no	1 1101	E. North	Avenue, Ba	altimo	re, MD 21202			
	shook, or heart failure. List Dnly	one cause on each line						Interval Between			
	disease or condition	cressive 1	1/201	focul	Louk	aluceal	unt or	The 2 cuty			
	DUE TO (OR AS A CONSEQUENCE OF):										
z	Sequentially list conditions. MMEDIATE CAUSE (Final disease or condition resulting in death)										
일	if any, landing to immediate										
S	cause. Enter UNDERLYING CAUSE (Disease or Injury										
	that initiated events resulting in death) LAST	DUE TO (OR AS A CONSE	DUENCE OF):								
CERTIFICATION	d										
AP.	PART ii. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS										
5	PERFORMED? AVAIL										
NE I							,	OF DEATH?			
ž	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN										
CIA	25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL: OTHER										
YSI		tient 2 ER/Outpetient 3		THER: Nursing Nome	5 Residence	6 Other (Specify)					
PHYSICIAN: MEDIC		OATE OF INJURY (Month, Day, Year)	265. TIME				SCRIBE HOW INJURY OCCURED				
BY	1 Naturel 5 Pending 2 Accident Investigation		M 1 TYES 2 NO								
	o Codid Not be	me, ferm, str	eet, factory, office		281. LOCATION (Street and Number or Rural Route Number, City or Town, State)						
COMPLETED		4 Number Getsturbed									
APL	299. CERTIFIER (Check only one)										
ő	2 MEDICAL EXAMINER: On the I	pasis of examination and/or i	investigation,	In my opinion, de	ath occured at the	time, data and place, and	due to the ce	use(s) and menner so stated.			
BE	29b. BIGNATURE AND TITLE OF CERTIFIER				29c. LICENSE NUI		29d. DATE SIG	GNED (Month, Day, Year)			
2	James J. Mus				04811	7	Mec	ember 11, 1995			
	30. NAME AND ADDRESS OF PERSON WHO COMPLE	TEO CAUSE OF DEATH (ITEI	M 27) (Type, P	rine)	111	12	1+-	more, MD			
	7		را الس	Marci	N HEXP	, rey De	Ul.	noic, mi)			
	DEU 1 5 1995 32. F	REGISTRAR'S SIGNATURE									



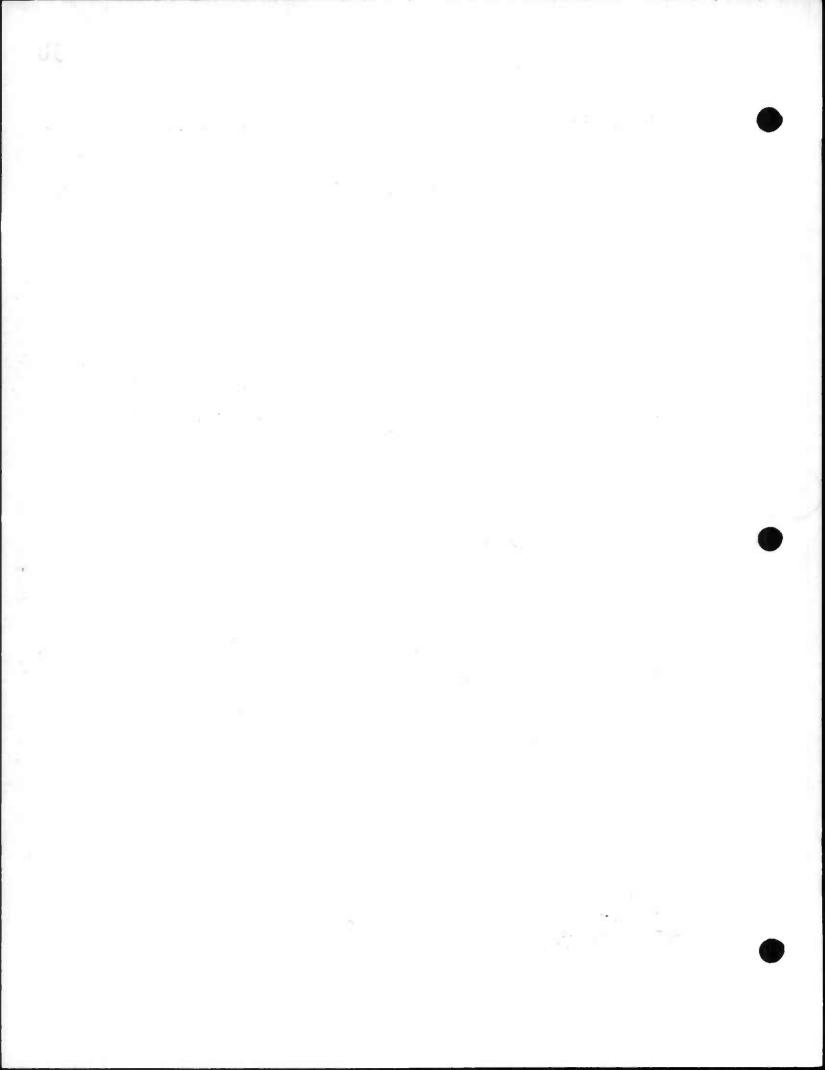
BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours are death. Page 6 may be retained by the hosp TO THE FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detache be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.		
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DIVISION OF VITAL RECORDS, P.O. BOX 68760

	1 - FOR STATE OF MARYL REGISTRAR	AND / DEPARTMENT O	F HEALTH AND I	MENTAL HYGIENE			
	1. DECEDENT'S NAME (First, Middle, Last)	OZIIII IOAI E	JI DEATH	2. DATE OF DEATH		3. TIME OF DEATH	
	HELFN SALEM			DELEMBER	11. 1995	10:02 P M	
	4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE	(In yrs. lest birthday) IF UNDER 1 YE	AR IF UNDER 24 HRS.	7. DATE OF BIRTH		IPLACE (State or Foreign	
	051-26-2474 1 □ M 2 ☑ F 63 9a. FACILITY NAME (If not institution, give street and number)	YRS.	YS HOURS MIN. WH OR LOCATION OF DE	Nov. 18, 19	932 Nev	y York	
STOR		PITAL GL	EN BUR		AVNE !	Jewo DEL	
DIRECTOR	MD Anne Arundel	10c. CITY, TOWN OR L Annapol				10d. INSIDE CITY LIMITS? 1 TYES 2 NO	
FUNERAL	130 Hearne Road, Apt. 704		101. ZIP CODE 21401		USA	VHAT COUNTRY?	
B∀	11. MARITAL STATUS 1 Never Merried 2 Merried 3 Wildowed 4 Divorced 12. WAS DECEDENT EVER IF FORCES? 1 YES IF YES, GIVE WAR OR D.	2 NO If ye	DECENDENT OF HISPAN s, apocify Cuban, Mexican YES 2 NO Specify		No- 14. RACE Black Speci	- American Indian, t, White, atc.	
COMPLETED	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	16a. OECEDENT'S USUAL OCCU (Give kind of work done durin life. Do NOT usa retired.)	g most of working	16b. KIND OF BUSIN			
₹ E		CRT Opera		Bank			
ပ္ပ	17. FATHER'S NAME (First, Middle, Last) William Gilinsman			ME (First, Middle, Maiden Su			
BE				erine Daly			
10	190.INFORMANT'S NAME (Type/Print) Carol Salem-Abbott	196. MAILING ADDRESS (Str. 926 Coach))1	
		.PLACE AND DATE OF DISPOSITIO	N (Name of		TION — City or To	wn, State	
	4 Donation 5 Other (Specify)Me	tro Cremato:	cy			ore, MD	
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE	22. NAM	COESTV FU	ineral Hom	ne. P.A		
	Dalsek A Chill	12	Ridgelv	Ave. Anna	polis.	MD 2140	
Z		ach line.				interval Between Onset end Death	
CERTIFICATION	Sequentially list conditione, if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated eventa reculting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):						
MEDICAL (PART II. Other aignificant conditions contributing to deeth be CHRONIC OBSTRUCTIVE PULMO ARTERY DISEASE; PERIPHEN	NARY DISEASE	CORONAR		D?	WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO	
ž	DID TOBACCO USE CONTRIBUTE TO CAUSE O			T M			
S		26. PLACE OF DEATH (Check only	one)				
YSI	EXAMINER? 1 YES 2 NO HOSPITAL: 1 Synpatient 2 ER/Outp	atlent 3 DOA 4 Nursing	Home 5 - Residence (8 Other (Specify)			
BY PHYSICIAN:	27. MANNER OF DEATH 1. Netural 5 □ Pending 2 □ Accident Investigation	28b. TIME OF 28c.	INJURY AT WORK? YES 2 NO	28d. DESCRIBE HOW INJU	JRY OCCUREO		
		— At home, ferm, street, factory, (office	281. LOCATION (Street and City or Town, State)	Number or Rural R	oute Number,	
COMPLETED	29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the best of my knowledge of the manual of the best of the best of my knowledge of the manual of the best of	edge, death occurred at the time, and/or investigation, in my opinion	date and place, and due t	to the cause(a) and manner time, data and place, and d	r as stated. lue to the cause(s)	and manner as stated.	
BE	296. SIGNATURE AND TITLE OF CERTIFIER MD		29c, LICENSE NUM D4545	BER 2	9d. DATE SIGNEO		
2	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DE	ATH (ITEM 27) (Type, Print)	,	_	TITOTI	11/1743	
	JOSHUA IMPERIO. 30	HOSPITAL	- DRIVE,	GLEN BU	IRNIE	MO 21041	
- 1	DEC 1 5 1995	II, ne					





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		FOR STATE 1 - STATE REGISTRAR	OF MARYLAND / DI	EPARTMENT OF H	EALTH AND M DEATH	ENTAL HYGIENE REG. NO.	
			EET		17	DEC 13	1995 3.36 A
Pin		4. SOCIAL SECURITY NUMBER 240-36-9134 5. SEX 1 M 2		YRS. MONTHS DAYS	HOURS MIN.	n DATE OF BIRTH (Month, Day: Year) Narch 28,27	8. BIRTHPLACE (State or Foreign Country) NC .
1. 2. 3 should	TOR	90. FACILITY NAME (If not institution, give street and nut Sinai Hospital RESIDENCE OF DECEDENT			timore	H 9c. COI	N/A
Pages	DIRECTOR	10s. STATE 10b. COUNTY N/		Ba]	timore		10d. INSIDE CITY LIMITS? 1 YES 2 NO
020 physician. burial-transit permit.	NERAL	535 Sheridan Aven	ue	101,	ZIP CODE 2121	2	USA
AND 21215-0020 the hospital or attending physician, detached for use as the burial-tran	BY FUN	1 Never Merried 2 Merried FORCE	ECEDENT EVER IN U.S. ARMED S? 1 YES 2 XNO , GIVE WAR OR DATES		cify Cuban, Mexican,	ORIGIN? (Specify Yee or No— Puerto Rican, etc.)	14. RACE — American Indian, Black, White, etc. Specify: Black
MARYLAND 21215-0020 retained by the hospital or attending physic 5 should be detached for use as the bunal notified at once.	LETED		(Give k	DENT'S USUAL OCCUPATION find of work done during mos NOT use retired.)	t of working	16b. KIND OF BUSINESS/IN	DUSTRY
rLAND by the hospit be detached at once.	E COMPLET	12th 17. FATHER'S NAME (First, Middle, Last) Frank Moore Sr.		Beauticia	16. MOTHER'S NAME	Hair (First, Middle, Melden Surneme) ssie Konegy	
	TO BE	190. INFORMANT'S NAME (Type/Print) Frank Moore Jr.	19b. M/	AILING ADDRESS (Street on 231 E. Be]	d Number or Rural Rou	nte Number, City or Town, State, Zi	ip Code) to, Md. 21239
FORE e 6 may rector, pa		20e. METHOD OF DISPOSITION 1XC Burlel 2 Cremetton 3 Removal from 5 4 Donation 5 Other (Specify)			ery 12/1	5/95 Balti	City or Yown, State more, Md.
2 5 3 B		21. SIGNATURE OF FUNERAL SERVICE LICENSEE	age	5502		Avenue Bal	neral Service to, Md 21215
ted with the completely filled in by the campiletely filled in by the isal, cremation, or removal event, the medical		23. PART .* Enter the disesses, or complication ahock, or heart failure. List only of the complete that the complete tha	ne cause on each line.	F LUNG/ME		s cerdiac or respiratory as	rrest, Approximata Interval Batwee Onset and Dest
P.O. BOX 68 th certificate be executed by the physician and if Hygiene prior to burn or other traumatic	CERTIFICATION	Sequentially list conditiona, if smy, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initieted events resulting in death) LAST	DUE TO (OR AS A CONSEQUEN				
CORD; iries that the signed by the Health and M ws any linju	MEDICAL	PART II. Other significant conditions contributed to the significant conditions conditions contributed to the significant conditions contributed to the significant conditions contributed to the significant conditions con	ting to death but not result CARDIO MY OPA	iting in the underlying	ceuse given in Pa	PERFORMED?	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 N NO
AL has b Dept.	SICIAN: I	DID TOBACCO USE CONTRIBUTE 1 25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PLACE OF	F DEATH (Check only one)	UNCERTAIN	DZL .	
OF PHYSIC this ce with th	PHY	1 VES 2 TNO T INPut 27. MANNER OF DEATH 1 Netural 5 Pending 20e. 1	ent 2 ER/Outpetient 3 E	b. TIME OF 28c. INJU INJURY WOR	5 Residence 6 RY AT 2 RY S 2 NO	Other (Specify) Bd. DESCRIBE HOW INJURY OF	CURED
VISIC STOR: A after d	ETED BY	3 Suicide 280.1	LACE OF INJURY — At home, uliding, etc. (Specify)			Bt. LOCATION (Street and Number City or Town, State)	v or Rural Route Number,
토로	COMPLE	29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the bi					
TO THE HOSPI TO THE FUNER be filed within	TO BE	29b. SIGNATURE AND TITLE OF CERTIFIER AUL SEC. 30. NAME AND ADDRESS OF PERSON WHO COMPLET	al DO		A\$ 240 23	21 PJ9945 >	DEC 13, 1995
		PAUL SEGAL,		VEDERE AV	E, BAU	IMORE MD /	SINAL HOSPITAL
		DEATER THE A	Twolor Royall	5			

 Pages 1, 2, 3 should

permit.

burial-transit

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within A hours after death. Page 6 may be retained by the hospital or attends	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as it	n 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
HE HOSPITAL OR ATTE	HE FUNERAL DIRECTOR	ed within 72 hours after	DRTANT: If Item 28
5	6	90	M

Item#1.G-film 730 per FH. 12/15/95 P.C
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 - STATE REGISTRAR CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH Wiley .1995 10 Sturdivant December Julius 11:30 A 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign Country) Sep. 29, 198-30-2967 1 M 2 - F 56 YRS. 1939 Pennsylvania 9s. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Maryland General HOspital Baltimore City Baltimore City RESIDENCE OF DECEDENT 10a. STATE 10c, CITY, TOWN OR LOCATION 10d. INSIDE CITY N/A Baltimore Maryland 1 X YES 2 | NO FUNERAL 10e. STREET AND NUMBER 101. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 501 Dolphin Street 21217 Apt. 804 U.S.A. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 \bigcirc YES 2 \bigcirc NO IF YES, GIVE WITH OR DATES 2/15/57-4/29/6013. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or NoIf yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Married 1 YES 2 X NO BY Specify: 3 Widowed 4 Divorced Specify: Black COMPLETED 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only hi Schwartz & Sons Elementary/Secondary (0-12) College (1-4 or 5+) 12th Route Salesman Distributors 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Fulton Sturdavant Bertha Womack BE THE INFORMANT'S NAME (Type-Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
459 WATTY COURT, BALTIMORE, MD 21201 2 Eileen Sturdavant METHOD OF DISPOSITION 20c. LOCATION - City or Town, State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE Burtel 2 Cremation 3 1 Re Garrison Forest VA Cem. 4 Donation 5 Other (Specify) 12/15 Owings Mills, MD 21. BIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF EACUTY
March Funeral Home East 1101 E. North Avenue, Baltimore, MD 21202 ins, or complications that caused the deeth. Do not entar the mode of dying, such as cardiec or respiratory arrest, shock, or heart failure. List Dniy Dne cause Dn each iina. Intarval Between IMMEDIATE CAUSE (Final Onset and Death disease or condition Lung Cancer reaulting in death) DUE TO (OR AS A CONSEQUENCE OF): CERTIFICATION Sequantially flat conditions, if any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF): cause. Entar UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other aignificent conditions contributing to death but not resulting in the underlying cause given in Part i. MEDICAL 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? PERFORMED? 1 TES TONO 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \(\Boxed{1}\) NO \(\Boxed{1}\) UNCERTAIN \(\Boxed{1}\) PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL: OTHER: 1 TES 2XXNO Inpetient 2 ER/Outpetient 3 DOA 4 Nursing Home 5 Residence 8 Other (Specify) 27. MANNER OF DEATH 28s. DATE OF INJURY (Month, Day, Year) 28b, TIME OF INJURY 28c. INJURY AT 28d, DESCRIBE HOW INJURY OCCURED 1XXNatural 5 Pending м 1 YES 2 NO BY 2 Accident 28s. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 8 Could not be COMPLETED 4 Homicide datermined 29e. CERTIFIER
(Check only one)

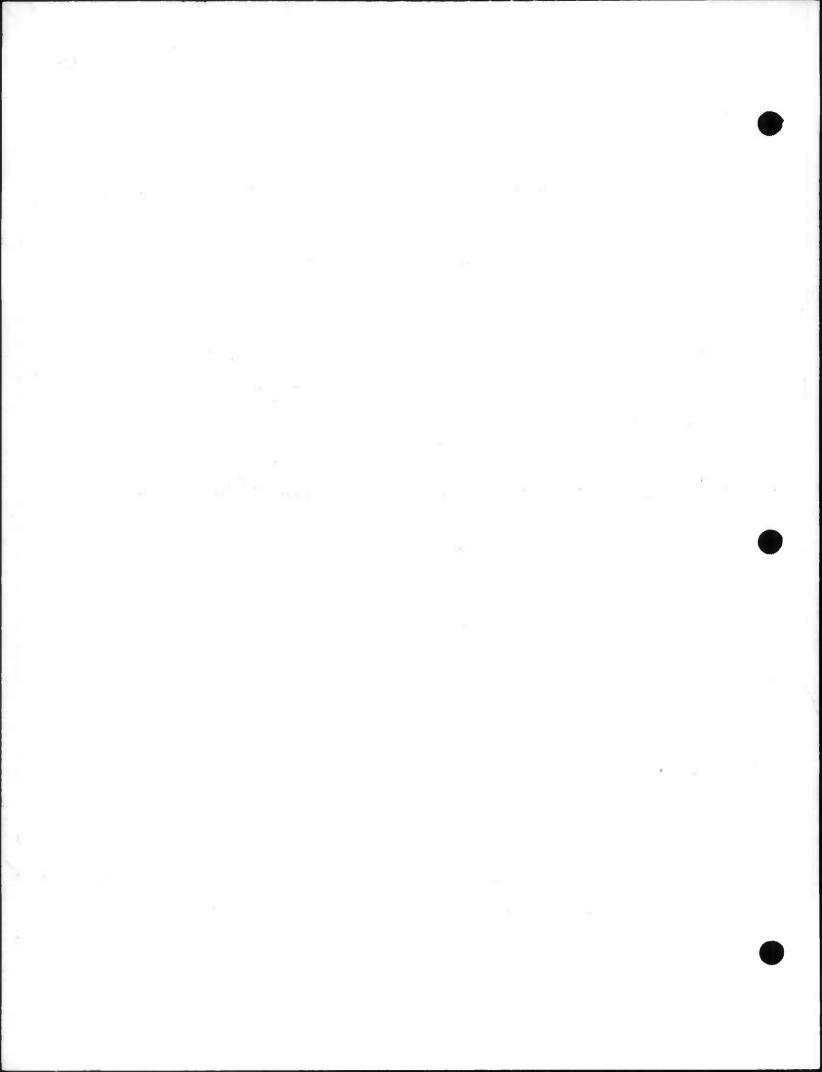
2 MEDICAL EXAMINES: On the best of my knowledge, death occurred at the time, date and place, and dus to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On the beele of examination end/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(e) end manner es stated. 29b. SIGNATURE AND TYTLE OF CERTIFIER 29c. LICENSE NUMBER BE 29d. DATE SIGNED (Month, Day, Year) Sawoka 89248 ▶ December 10,1995

31. DATE FILED (Month, 1995)

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

Serena Barakat, M.D. c/o Maryland General Hospital

32 REGISTRAR'S SIGNATURE



Please Type or Print in Black Indelibie ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 5 Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Day 1995 **Physician** Month 12, 8:45am Jean Yvonne Sigmon Dec. /Medical 4b. City, Town, or Location of Death 4a. Facility Nama (If not institution, giva street and number) 4c. County of Death Examiner Baltimore 1683 Essextown Circle If Undar 1 Yaar | If Undar 24 Hrs. 5. Social Security Number Birthplaca (Stata or Foreign Country) 7. Aga (In yrs. last birthday) Days 1□ M 2□ F 58 217-34-3644 Vrs Maryland Usual Rasidance ot Decedant 10a Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits Md. Baltimore Essex 1 Yas 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21221 USA 1683 Essextown Circle Funeral 12. Was Decedant Evar in U,S. Armed Forcas? 1 ☐ Yas 2 ∑ No If Yas, Giva Yaar or Datas: 13. Was Decedant of Hispanic Origin? (Specify Yas or No If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian, Black, Whita, atc. 11 Marital Status 1 Never Married 2 Married 1 ☐ Yas 2X No Specify: Specify à 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use ratired) 15. Decedant's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Coilega (1-4or 5+) 10th Homemaker own home 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Surnama) Harry Rudasill Ruth Selby 19a. Intormant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Coda) 1683 Essextown Circle Baltimore Md. 21221 Thurman Sigmon 20b. Place of Disposition (Nama of cematary, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata 1 Burial 2 □ Cramation 3 □ Ramoval trom Stata 4 ☐ Donation 5 ☐ Other (Specify) Holly Hill Cemetery 12/14/95 Baltimore Md. 22. Nama and Addrass of Facility
Connelly Funeral Home of Essex 21. Signatura of Funeral Service Licenses 300 Mace Ave. Baltimore Md. 21221 onn 23a. Parf1. Entar tha disaale, or complications that caused the death shock, or heart failure. List only one cause on each line. Do not antar tha mode of dying, such as cardiac or respiratory arrest, Approximata Interval Batween Onset and Death Immediate Causa (Final disaasa or condition rasulting in death) Examiner Sequentially list conditions, if any, laading to immadiata causa. Enter Underlying Causa (Disaesa or injury that initiated evants rasulting in death) Last Physician/Medical Dua to (or as a consequance ot): Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yee 2 ☐ No 3 Probably 4 Unknown þ 24b. Wara autopsy findings available prior to completion of cause of daath? Completed 24a. Was an autopsy 1 Yas 20 No 1 TYas 2 No Be 25. Was casa ratarred to medical 28. Place of Death (Check only ona) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yas 2 No 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner ot Death 28b. Tima of 28c. Injury at Work? 28d. Dascribe how injury occurred 1 Natural 5 Panding Invastigation 1 ☐ Yas 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 3 ☐ Suicide 6 Could not be datamined 28e. Place of Injury - At homa, tarm, street, tactory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledga, death occurred at tha time, date and place, and dua to tha cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifler Medicai 29b. Signature and titla of certifian 29c. Licansa number 29d. Data signed (Month, Day, Year)

The lew requires that the death certificate be executed Box 68760. Records, P.O. Division of Vital Hospital or Attending Physician: To the Hospital or Attendit within 24 hours after death.

To the Funeral Director: All completely filled in by the fu

Funeral

Director

28a-f show

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items 23s

should be filed within 72 hours after of Mental Hygiene. marked other than "natural", or iter

permit. Peges 1 and 2 should be file Department of Health end Mental Hys Important: If flem 27 is marked othe any injury or other traumatic avant, since.

Physician /Medical

Examiner

attending physician end for use es the buriel-transit

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cate hes been signate, page 2 should b

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After

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Bartimore, Maryland 21215-0020

traumetic avant, the Medical Examiner must be notified at

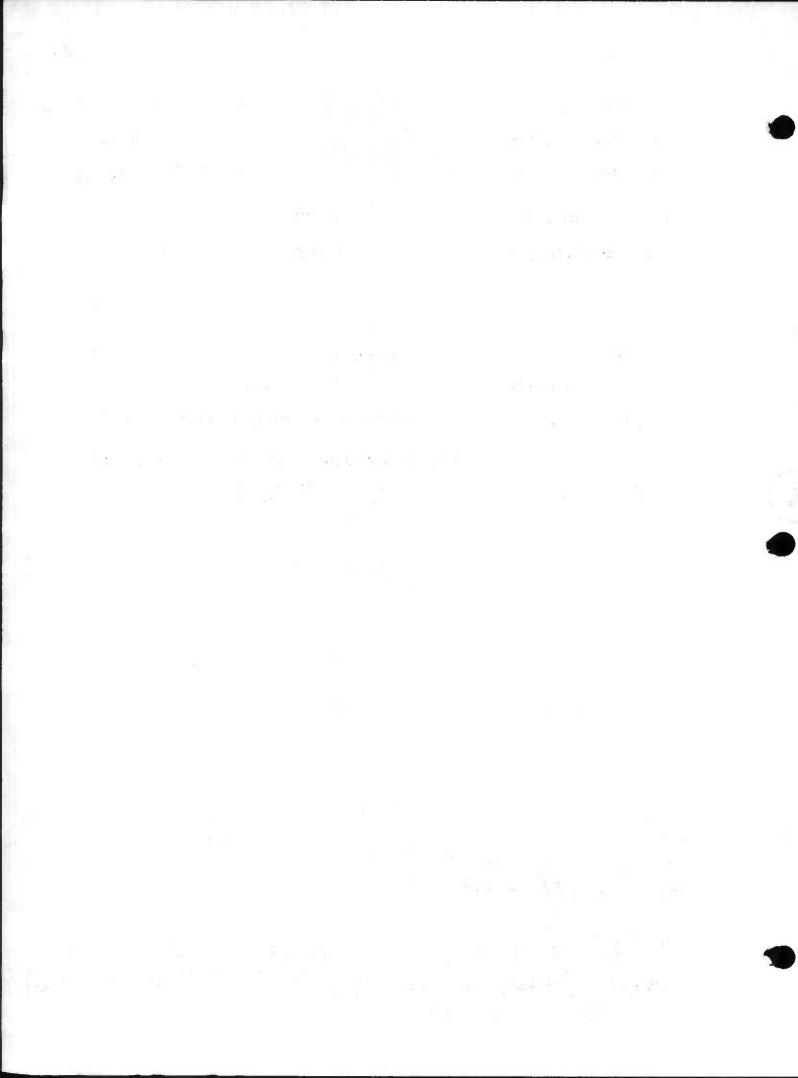
with the Maryland

State Registrar

32. Ragistrar's Signature

causa ot death (Item 23a) (Type, Print)

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	PITAL

		DEPARTMENT OF HEALTH AND I		30102
	1. DECEDENT'S NAME (First, Middle, Last) Robert Taywr, Jr	RITIFICATE OF DEATH	PEG. NO. 2. DATE OF DEATH MONTH DAY DAY 12, 199	3. TIME OF DEATH
	4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. lest $2 \mid 3 - 76 - 1309$ 1 $4 \mid 4 \mid 4 \mid 5 \mid 5$	birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) 2-13-1959	BIRTHPLACE (State or Foreign Country)
TOR	9a. FACILITY NAME (If not institution, give street and number) Sinai HUSDHU	Baltimore		OF DEATH NA
DIRECTOR	10e. STATE 10b. COUNTY M d Ba (4)	10c. CITY, TOWN OR LOCATION Baltmore-Ess	ex	10d, INSIDE CITY LIMITS? 1 YES 2 NO
FUNERAL	902 Ashbridge Drive Apt	101, ZIP CODE 21221	10g. CITIZEN	OF WHAT COUNTRY?
B	11. MARITAL STATUS 1 Never Married 2 Married 3 Wildowed 4 Divorced 12. WAS DECEDENT EVER IN U.S. ABN FORCES? 1 VES 2 NO IF YES, GIVE WAR OR DATES		n, Puerto Rican, etc.)	RACE — American Indian, Black, Whita, atc. Specify: Bkull
COMPLETED	(Specify only highest grade completed) (Giv	CEDENT'S USUAL OCCUPATION we kind of work done during most of working Do NOT use retired.) hes tos Remover	Marcor En	Dironmental
BE CON	TRATHER'S NAME (First, Middle, Last) KODENT M. Taylor, SV	18. NOTHER'S NA	ME (First, Middle, Meiden Surname)	L.
TO E	Virginia Taylor	MAILING ADDRESS (Street and Number of Pural)	. 111 1	Essex, Md 2122
	1 Buriel 2 Cremation 3 Removal from Stata cemelery, crep 4 Donation S Other (Specify)	ND DATE OF DISPOSITION (Name of CH	DATE 200-LOCATION - CHY	u a a l
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE	22, NAME AND ADDRESS OF FA	West ash Au	Baltomel
	23. PART 1. Enter the disease, or complications that caused the deshock, or heart feliure. Liet only one ceuse on each line. IMMEDIATE CAUSE (Fine) disease or condition resulting in death) Due to (or as Alconseo	ailur - Proumusia		Approximate interval Between Onset and Death
ERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	· · · · · · · · · · · · · · · · · · ·		
L CER	PART II. Other significant conditions contributing to death but not re	eauiting in the underlying ceuse given in	Part I, 24s. WAS AN AUTOPSY	24b. WERE AUTOPSY FINDINGS
MEDICA			PERFORMED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
SICIAN:				
PHY	EXAMINER? 1 YES 2 PO	DOA 4 Nursing Home 5 Raeldenca 28b. TIME OF NURSING WORK? M 1 YES 2 ND	8 Other (Specify) 28d, DESCRIBE HOW INJURY OCCUR	ED
ETED BY	2 Accident investigation 3 Sulcide 8 Could not be detarmined 28e. PLACE OF INJURY — At hor building, atc. (Specify)	me, farm, street, factory, office	281. LOCATION (Street and Number or I City or Town, State)	Bural Route Number,
COMPLE	29a. CERTIFIER (Check only one) CERTIFYING PHYSICIAN: To the best of my knowledge, dea			euse(s) and manner og stated.
TO BE C	29b. SIGNATURE AND TITLE OF CERTIFIER 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM	29c. LICENSE NUI A5 240 23	MBER 29d. DATE SI	GNED (Month, Day, Year)

OF GEATH (ITEM 27) (Type, Print)

rasignit

32. REGISTRAR'S SIGNATURE

MD

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DIVISION OF VITAL RECORDS, P.O. BOX 68760

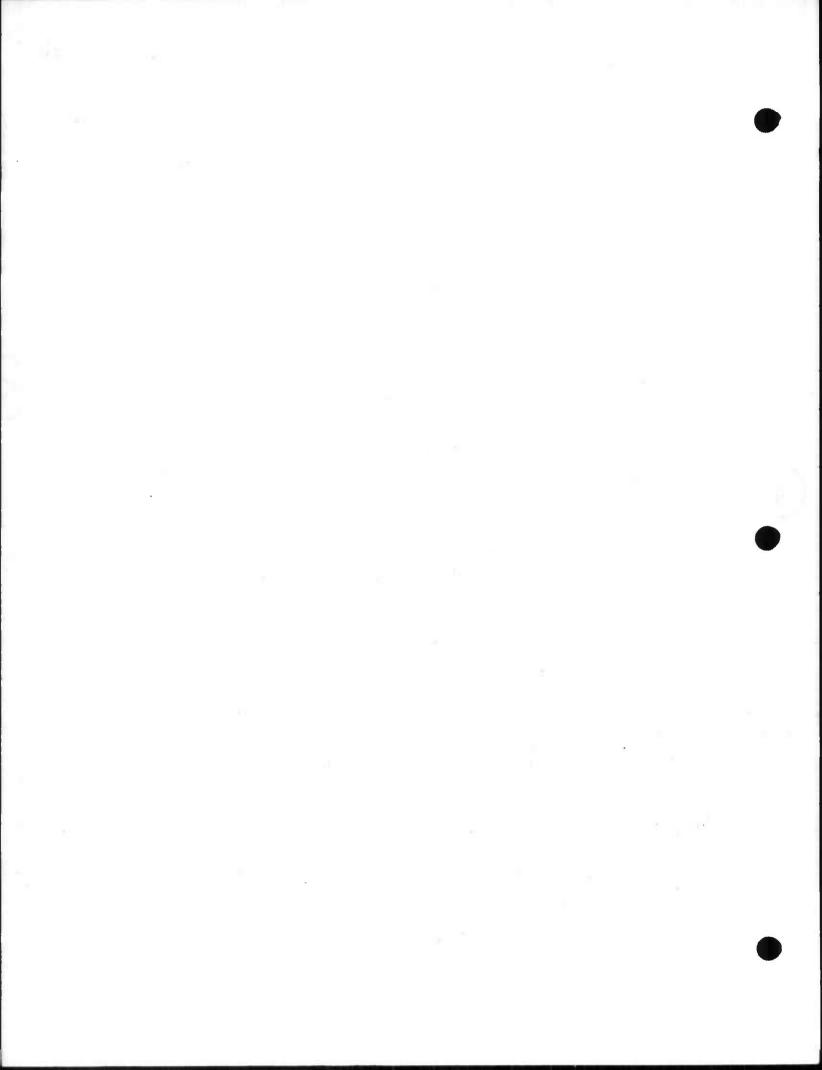
31. DATE FILED (Month, Day, Year)
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32, REGISTRAR'S SIGNATURE

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						20	00100
	1 - STATE REGISTRAR	STATE OF MARYLAND /		TOF HEALTH AND		_	
	1. OECEDENT'S NAME (First, Middle, Last)		-IIIII IOAI	L OI BLAIN	REG. NO		3. TIME OF DEATH
	Adelita Thomas				Dec 0	6 1995	0745 a M
	4. SOCIAL SECURITY NUMBER 215-01-1987	5. SEX 1 M 2 F 8. AGE (In yrs. les	YRS. IF UNDI	ER I YEAR IF UNDER 24 HRS. DAYS HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year)	1914 8. BIRT	HPLACE (State or Foreign try)
ac 9	9a. FACILITY NAME (If not institution, give stre		96. CU	Y, TOWN OR LOCATION OF O	EATH	9c. COUNTY OF I	
5	RESIDENCE OF DECEDENT	SING HOME		Sa 170		NA	
DIRECTOR	10a. STATE 10b. COUNTY	AC	Balt	ORLOCATION			10d. INSIDE CITY LIMITS? 1 X YES 2 NO
FUNERAL	1201 ACGULE	- Ave.		10f. ZIP COOE	7	10g. CITIZEN OF	
ВУ	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEOENT EVER IN U.S. APFORCES? 1 YES 2 IN IF YES, GIVE WAR OR DATES	IMED 13	WAS DECENOENT OF HISPA If yes, specify Cuban, Maxic: 1 YES 2 Specifi	an, Puerto Rican, atc.)		E — American Indian, ck, White, atc.
LETED	15. OECEDENT'S EDUCA (Specify only highest grade of Elementary/Secondary (0-12)	College (1-4 or 5+)	CEDENT'S USUAL of work done Do NOT use retired.	during most of working	16b. KIND OF BU	SINESS/INDUSTRY	
COMPL	17, FATHER'S NAME (First, Middle, Last)	NA	Home	Maller ev	AME (First, Middle, Meiden	ne	
BE C	HARRY Steve	NOSON		Emma	+ GARD		
TO B	19 TWFORMANT'S MAME (Type/Print)	19		SS (Street and Number or Rural			- 0
	20g, METHOD OF DISPOSITION	177.		Gyle Ave		Hd. Zi	511
	1 A Burial 2 Cremation 3 Ramov	rail from State cometery, cre	AND DATE OF DISPO	1 1 12	OATE 200 LO	CATION — City or To	own, State
	21. SIGNATURE OF FUNERAL SERVICE LICE		1 2 2 2 2 2	NAME AND AGORESS OF FA	CILITY	~ 106	TCV
	- Smorroude (Wellander,	1	LARCH FUNG	PRAC HON	B. It	115121212
	23. PART I. Enter the diseases, or co	implications that caused the de lat only one cause on each line	ath. Do not ante	er the moda of dying, auc	h as cardiac or reap	Iratory arreat,	Approximata
	IMMEDIATE CAUSE (Final disease or condition resulting in death)	SEPS15	•				Interval Between Onset and Death
		OUE TO (OR AS A CONSE	OUENCE OF):	11.0151			
8	Sequentially list conditions, b.	DUE TO (OR AS A CONSEC	THAS	VLCER			
CERTIFICATION	If any, leading to immediate cause. Enter UNDERLYING	202 10 (ON A3 A CONSE	ZUENCE OF):				
Ē	CAUSE (Disease or injury thet initiated events	DUE TO (OR AS A CONSEC	DUENCE OF):				
#	resulting in death) LAST						
_ 1	PART II Other algnificant conditions	contributing to deeth but not r	esulting in the u	nderlying ceuse given in	Part i. 24s. WAS AN	AUTOPSY 24E	. WERE AUTOPSY FINDINGS
MEDICA	KHEVMATOR	D ARTHRUS	TIS N	MALNUTLIT	ON PERFOR		AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
¥					_,		1 YES 2 NO
AN	DID TOBACCO USE CONTRI 25. WAS CASE REFERRED TO MEDICAL		TH YES E OF OEATH (Check		NZ		
SICI	PV 44444PPP	HOSPITAL:	OTHE		a C Other County		
PHYSICIAN:	27. MANNER OF DEATH	26a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF	26c. INJURY AT WORK?	26d. DESCRIBE HOW I	NJURY OCCURED	
BY	1 Natural 5 Pending 2 Accident Investigation		М	1 YES 2 NO			
	3 Suicide 6 Could not be 4 Homicide determined	28e. PLACE OF INJURY — At ho building, atc. (Specify)	me, farm, atreaf, fac	ctory, offica	26f. LOCATION (Street a City or Town, State)	and Number or Rural I	Route Number,
	29a. CERTIFIER 1 CERTIFYING PHYSICI	ANI To the heat of a viscous of					
COMPLET		AN: To the best of my knowledge, da On the bests of examination and/or i					s) and manner as stated.
ш	296. SIGNATURE AND TITLE OF CERTIFIE	100		29c. LICENSE NUI		29d. OATE SIGNED	
TO B	18mil	- wallau	ar.	D311	36	+ DEC	
⊢	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF OFATH //TEL	4 27) (Time Print)				



BALTIMORE, MARYLAND 21215-0020

Pages 1, 2, 3 should

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DIVISION OF VITAL RECORDS, P.O. BOX 68760

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withi	plete	crema	ent,
petro	COM	rial,	V9 3
exec	n and	10 PL	mat
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H H	HE FL	M pa	DRTA
TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physical properties of the propriet of the properties of the properties of the propriet of the properties of the propriet of the properties of the properties of the propriet of the properties of	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burla	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

PHYSICIAN:

BY

ETED

COMPL

BE

9

27. MANNEB-OF DEATH

Natural

7 Accident

3 | Buicide

4 Homicide

38104 FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO I. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 199 ervelle NATITAN THOMPSON DECEMBER 1040 A 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH (Month, Day, Year) 6-12-1908 IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign 1 M 2 - F DAYS HOURS 87 079-03-4074 A New York 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH Carroll Co. Gen. Hospital DIRECTOR Westminster Carroll RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Carroll Westminster 1 YES 2 NO FUNERAL 10s. STREET AND NUMBER 10g. CITIZEN OF WHAT COUNTRY? 1508 Amalfi Drive 21157 U.S.A. 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, stc.)

1 YES 2 NO Specify: 12. WAS DECEOENT EVER IN U.S. ARMED 14. RACE — American Indian, Black, White, etc. FORCES? 1 YES 2
IF YES, GIVE WAR OR DATES 1 Never Married 2 Merried 2 3 NO BY 3 🕅 Widowed 4 🗌 Divorced Specify White 16a. DECEDENT'S USUAL OCCUPATION COMPLETED 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only high (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5 +) Mechanic Automobile 17. FATHER'S NAME (First, Middle, Last) 18, MOTHER'S NAME (First, Middle, Maiden Sumeme) Nathan Thompson Izora Brown BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Elaine Carabell 1508 Amalfi Dr. Westminster, Md. 21157 20a. METHOD OF DISPOSITION

1 M Burlet 2 Cremetion 3 C

4 Donetion 8 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of OATE 20c. LOCATION — City or Town, State Burlet 2 Cremetion 3 Rem Hope Cemetery May 19, 1996 Nowwich, New York 21. SIGNATURE OF FUNERAL BERVICE LICENSES 22. NAME AND ADDRESS OF FACILITY Eckhardt Funeral Chapel Calibard 3296 Charmil Dr. Manchester, Md. 21102 23. PART i. Enter the diseases, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart follure. List only one cause on each line. Approximata intarvai Batween IMMEDIATE CAUSE (Final Onset and Daeth ACUTE MYUCARDIAL FORARCTION disease or condition resulting in death) OUE TO (OR AS A CONSEQUENCE OF) ARTERY DISEASE DUE TO (OR AS A CONSEQUENCE OF): sevens CERTIFICATION Sequentially list conditions, If any, leading to immediate cause. Enter UNDERLYING AUSTATE CANCER CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF) that initiated events. resulting in death) LAST PART II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part i. 24e. WAS AN AUTOPSY PERFORMED? MEDICAL 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 1 YES 2 NO

1 - YES 2 - NO

DID TOBACCO USE CONT	RIBUTE TO CAUSE OF DEATH	YES NO	UNCERTAIN
. WAS CASE REFERRED TO MEDICAL		DEATH (Check only one)	
EXAMINER? 1 YES 2 NO	HOSPITAL: 1 Dinpatient 2 ER/Outpatient 3 DO	OTHER:	5 Residence 6 Other (Specify)

28e. DATE OF INJURY 28b. TIME OF 28c. INJURY AT

1 YES 2 NO 26e. PLACE OF INJURY — At home, farm, street, tectory, office

28d. DESCRIBE HOW INJURY OCCURED 28t. LOCATION (Street and Number or Rural Route Number, City or Town, State)

290.	CERTIFIER Check only	CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(e) end manner as stated.
	one)	2 MEDICAL EXAMINER: On the basis of examination and/or immediation in the entire death accorded to the line.

MEDICAL EXAMINER: On the basis of examination end/or investigation	i, in my opinion, death occured at the time, date end place	ce, end due to the ceuse(s) end menner es stated.
E AND TITLE OF CENTIFIER Schreibfider, M.	29 LICENSE NUMBER ZZ/	29d. DATE SIGNED (Morith, Day, Year) December 13, 1995

Schneibfder, My ay

Pending Investigation

8 Could not be

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)	
)AN It- SCHOPER BEREN 200 MEMORIAL AVENUE	WESTHINSTER MARYCAN ()
31. DATE FILEO (Month, Day, Year) 32. REGISTRAR'S SIGNATURE	
DEC 1 5 1995	21157

This Shudson Kardall

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Items#1.10.b.19.b.G-film 731 per FH. 1/5.96 P.C

	Items10c,1Ce,19b	12-22-95 FilmG730 W STATE OF MARYLAND / DEPA		MENTAL UVCIEN	E	
	1 - STATE REGISTRAR		FICATE OF DEATH	REG. NO.		
	1. DECEDENT'S NAME (First, Middle, Last) Harriet			2. DATE OF DEATH MONTH D		
	Harrictt Smit	h Thurston 5. SEX 6. AGE (In yrs. last birthday		December		95 3:30a M
	549-09-6857	1 □ M 2 🗶 F 84 YRS.	MONTHS DAYS HOURS MIN.	Dec. 6, 19	11 Mi	chigan
стов	90. FACILITY NAME (If not institution, give str Meridian Nursing He		9b. CITY, TOWN OR LOCATION OF D Annapolis	DEATH	9c. COUNTY OF Anne	Arundel
DIRECT	RESIDENCE OF DECEDENT 100. STATE 10b. COUNTY MD Prin	M A	ITY, TOWN OR LOCATION Chevy	Chase		10d. INSIDE CITY LIMITS? YES 2 NO
FUNERAL	100. STREET AND NUMBER Dorse! 5100 Dorsett Avenue		101. ZIP CODE 20815		USA	WHAT COUNTRY?
BY FUNE	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPA If yee, specify Cuban, Mexic 1 YES 2 NO Speci	an, Puerlo Rican, etc.)	Ble	CE — American Indian, ack, White, etc.
ETED.	15. DECEDENT'S EDUC. (Specify only highest grade of Elementery/Secondary (0-12)	College (1-4 or 5 +) (Give kind of life. Do NOT	'S USUAL OCCUPATION If work done during most of working use retired.)		SINESS/INDUSTRY	
COMPL	12	4 Account		Accoun		
ш	17. FATHER'S NAME (First, Middle, Lest) Thomas Palme	er Smith		AME (First, Middle, Melden e Laura M		
TO B	190. INFORMANT'S NAME (Type/Print) Margaret Mullac	195. MAILIP 19 1638	Cherry Stone Cherry	Drive, A	water	21037 is, MD 214
	20e. METHOD OF DISPOSITION 1	20b. PLACE AND DAT	E OF DISPOSITION (Name of		OCATION — City or	
	4 Donetion 8 Other (Specify)	Metro C	rematory 22. NAME AND ADDRESS OF F	/2/14 Bal	timore	, MD
	Thomas A	Dardostes	Hardesty F	uneral Ho		
		omplications that caused the reeth. Do				Approximate interval Between Onsat and Death
CERTIFICATION	Sequentially list conditiona, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (OR AS A CONSEQUENCE		olism	/	
MEDICAL	PART II. Other algorificant conditions Devention Bilader Lch DID TOBACCO USE CONTR		ud Slocations res □ NO N UNCERTA	PERFOI	RMED?	4b. WERE AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
SICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO	26. PLACE OF DE HOSPITAL: 1 □ Inpatient 2 □ ER/Outpatient 3 □ DOA	OTHER: 4 Nursing Home 5 Residence	6 Other (Specify)		
Y PHY	27. MANNER OF DEATH 1 Natural 5 Pending 2 Accident Investigation		IME OF NJURY AT WORK? M 1 YES 2 NO	28d. DESCRIBE HOW	INJURY OCCURED	
TED B	3 Suicide 8 Could not be 4 Homicide determined	28e. PLACE OF INJURY — At home, ferri building, etc. (Specify)	n, street, fectory, office	261. LOCATION (Street City or Town, Stete		al Route Number,
COMPLE	Lorent Comp	CIAN: To the best of my knowledge, death occurs: On the basis of axamination end/or investigation				e(a) end manner es stated.
) BE C	200. SONATURE AND TITLE OF CERTIFIER	Country	29c, LICENSE N	653	29d. DATE SIGN	ED (Month, bey, Year) 12/95

MD 21401

DHMH-16 Rev 1/89



31. DATE FILED (Morth, Day, Year) DEC 1 5 1995

32. REGISTRAN'S SIGNATURE

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BALTIMORE, MARYLAND 21215-0020

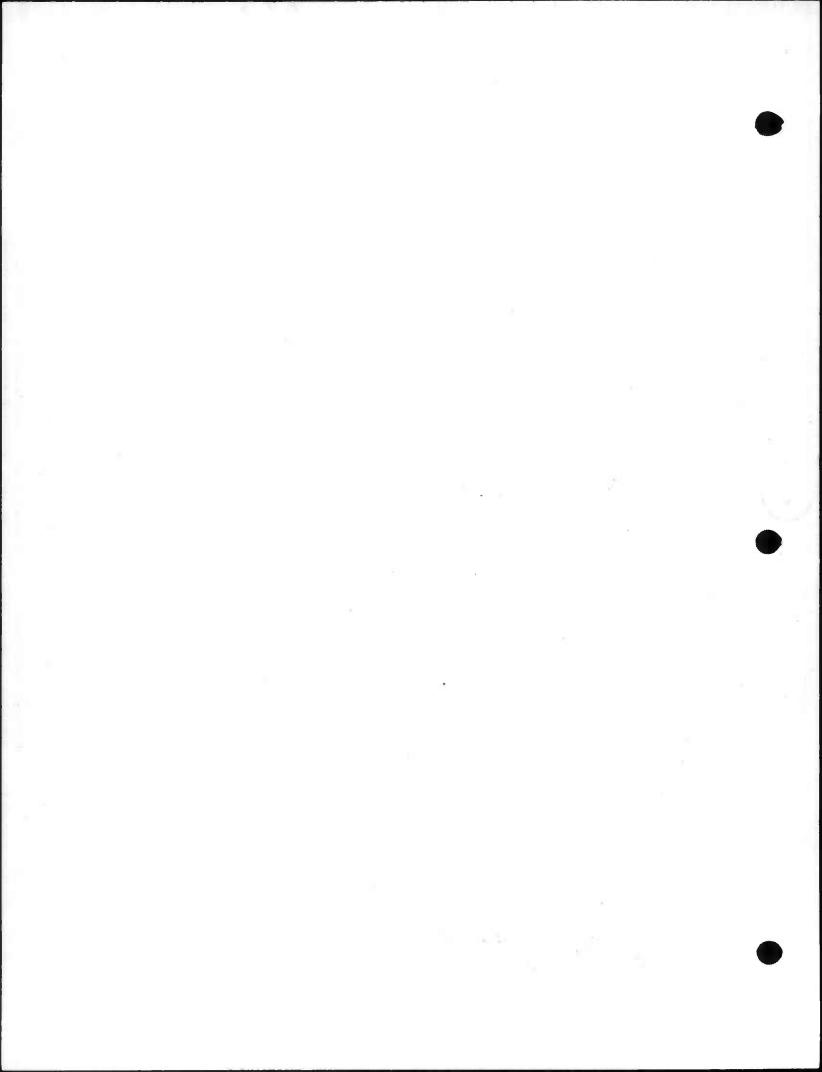
DIVISION OF VITAL RECORDS, P.O. BOX 68760

BALTIMORE, MARYLAND 21215-0020	TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be relatined by the hospital or attending physician.	s certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	edical examiner must be notified at once.
DIVISION OF VITAL RECORDS, P.O. BOX 68760	law requires that the death certificate be executed within 24 h	certificate has been signed by the attending physician and completely filled in by the funera In the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	1, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
DIVISION OF VITAL	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The I.	TO THE FUNERAL DIRECTOR: After this certificate has be filed within 72 hours after death with the State De	IMPORTANT: if Item 28 is marked, or item 23 show

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

	REGISTRAR		CERTIFI	CATE OF	DEATH	REG. NO).	
	1. DECEDENT'S NAME (First, Middle, Last)			m	2 0	2. DATE OF DEATH	MY YEAR	3. TIME OF DEATH
	Dr. Mary Xav	1er Verd	e.n	0.5	, P.		2 1995	3-15 PM
	1101/10/00/19	SEX 6. AGE (In yrs.		IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year)		/-
	9e. FACILITY NAME (If not institution, give street	end number)		9b. CITY, TOWN (OR LOCATION OF D	EATH 7	9c. COUNTY OF	DEATH
TOR	ST Agnes Hospital Baltmore NA RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION LIMIST? LIMIST? LIMIST? LIMIST?							A
) <u>ည</u>	10a. STATE 10b. COUNTY		10c. CITY	, TOWN OR LOCAT	TION			104 INDIDE OUTY
	7.2017							LIMITS?
FUNERAL	100. STREET AND NUMBER 1701 Gunn R	vad		101	ZIZ ZIZ	27	10g. CITIZEN OF	S.A
٦		WAS DECEDENT EVER IN U.S. FORCES? 1 YES 2		13. WAS DEC	ENDENT OF HISPA	NIC ORIGIN? (Specify Ye	s or No — 14. RAC	E — American Indian,
BY	1 Never Merried 2 Merried 3 Widowed 4 Divorced	IF YES, GIVE WAR OR DATES	No		ecify Cuben, Mexico 2 NO Specif	en, Puerto Rican, etc.) y:	Spe	Sk, White, etc. Slack
TED	15. DECEDENT'S EDUCATIO (Specify only highest grade comp	ON 16a.	DECEDENT'S U (Give kind of we life. Do NOT use	USUAL OCCUPATION OF MORE MORE DESCRIPTION OF M	ON est of working	16b. KIND OF BU	SINESS/INDUSTRY	
COMPLETED	Elementary/Secondary (0-12) Co	Aaster Darre	Tea	cher		Sch	100/	
Ö	17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NA	ME (First, Middle, Maiden	Sumame)	
BE	19e, INFORMANT'S NAME (Type/Print)				Mary	hanel		
2	Sister Alexis Fishe	w 0.5.P	70/	Sun R	and Number or Flural	Rouge Number, City or Tow	n, State, Zip Code)	1 21227
	20a. METHOD OF DISPOSITION 10 Burlel 2 Cremetion 3 Removal 1	from State 20b PLAC	CE AND DATE OF	F DISPOSITION (Na	Parent Parent	DATE 20c. LO	OCATION — City or T	own, State
	4 Donation 5 Dother (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY, +							11-14
	thome +	+ Ihm	psmJ	n Mary	100 Wa	bash An	2 Ball	Hd 21215
	23. PART I. Erger the diseases, or company of the c	olications that caused the	Seath. Do no	ot enter the mo	de of dying, auc	h aa cardiec or reap	iretory arrest,	Approximata
	IMMEDIATE CAUSE (Final	Siny one cause on each p	A					Onset and Death
	disease or condition resulting in death) a	STRO	KE					8 days
		DUE TO (OR AS A CON	SEQUENCE OF	1.00.	tus			
CERTIFICATION	Sequentially list conditions, b	DUE TO (OR AS A CON	SEQUENCE OF	icu	us			1042
¥	if any, leading to immediate cause. Enter UNDERLYING	HULONT	PARSI	· Dh				10 410
三	CAUSE (Disease or injury that initiated events the following that initiated events the following that initiated events the following that initiated events the following the following that initiated events the following the fol							
본	resulting in deeth) LAST							
	PART II. Other significant conditions co	intribution to death but no	et manufitime in	the underlying				
EDICAL	1 HF	to 0 - 1	lead 1/	the underlying	,	PERFOR		MAILABLE PRIOR TO
	The science and la seven duren 1 yes 20(NO OF DEATH?							
Σ	DID TOPACCO LICE CONTRIBU	ITE TO CALIEF OF D	FATUR VE					1 YES 2 NO
AN	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 125. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one)						100	
PHYSICIAN:	EXAMINER?	SPITAL:		OTHER:				
	1 YES 2 OOO 1 X	Inpatient 2 ER/Outpatient 28e. DATE OF INJURY	3 DOA			6 Other (Specify)		
	1 Natural 5 Pending	(Month, Day, Year)	INJU	RY WO	RK? /ES 2 NO	28d. DESCRIBE HOW I	NJURY OCCURED	
B	2 Accident Investigation 3 Suicide 8 Could not be	28s. PLACE OF INJURY — At	home, term, str			281 LOCATION (Street	and Number or Print	Christian March and
ETED	4 Homicide determined building, atc. (Specify)						node Namber,	
12	29e. CERTIFIER (Check only CERTIFYING PHYSICIAN:	To the best of my knowledge,	death occurred	f at the time, date	end place, end due	to the cause(e) and mer	nner ee stated.	
COMPL		the basis of examination end/						e) and menner as stated.
اسا	296. SIGNATURE AND TITLE OF CERTIFIER	1			29c. LICENSE NUI			(Month, Day, Year)
TO B	Hurkaran 2 11/1/16 12 211 CE							
	30. NAME AND ADDRESS OF PERSON WHO COI SAMBANDAM BASK	MPLETED CAUSE OF DEATH (I	TEM 27) (Type, 1	Vilke	us Avi	. Baltim	se Mo	21229
	31. DATE FILED (Month, Day, Year) DEC 1 5 1995 Julia	32. REGISTRAR'S SIGNATURE				()		,
1 1	LUEUT DISSO HOWE	ANDREA LABORAL						



TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Memai Hyglene prior to burial, cremation, or removal.

IMPORTANT: Il Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG NO.

CERTIFICATE OF DEATH	REG. NO.				
MONTH	OF DEATH DAY YEAR 3. TIME OF DEATH				
4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In vis. lost highdray) IF INNER 1 VEAR IN INNER 24 MIS 7 DATE	c-11-95 2-AM				
2 10 / 2 54/00 PT - 20 MONTHS DAYS HOUSE MIN (MONTHS DAYS	OF BIRTH 1, Day, Year) 23 - 195 7 B. BIRTHPLACE (State or Foreign Country)				
9e. FACILITY NAME (If not institution, give street end number) 9b. CITY, TOWN OR LOCATION OF DEATH	9c. COUNTY OF DEATH				
RESIDENCE OF DECEDENT	7 7 7 7				
10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION	10d. INSIDE CITY				
HEUINDAIL N. H. Balto RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY NA Baltimore	LIMITS?				
100. STREET AND NUMBER 270/ ROS/4n Avenue 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 VES 2 MNO 14. WAS DECEMBENT OF HISPANIC ORIGIN 15. WAS DECEMBENT OF HISPANIC ORIGIN 16. ZIP CODE 272/6 17. MARITAL STATUS 18. WAS DECEMBENT OF HISPANIC ORIGIN 19. Specify Cuben. Marken. Plusto 6	10g. CITIZEN OF WHAT COUNTRY?				
11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECEMENT OF HISPANIC ORIGIN	0,0.,				
	17 (Specify Yes or No.— 14. RACE — American Indian, Black, White, etc.				
3 Widowed 4 Divorced IF YES, GIVE WAR OR DATES 1 YES 2 NO Specify:	Specify: Plane				
	Diade				
(Speciny only nighest grade completed) (Give kind of work done during most of working	KIND OF BUSINESS/INDUSTRY				
Elementary/Secondary (0-12) College (1-4 or 5+)	uhn Taylor				
NA Carpenter Asst	Contractors				
17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, A	Aiddle, Maiden Surname)				
	5.				
0	-29				
	per, City or Town, State, Zip Code)				
File HII 2101 RUSIUM the	Balto, My 21216				
20a_METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of	20c/LOCATION — City or Town, State				
	9 hansdown Nd				
1) Burtel 2 Cremation 3 Removel from State 4 Donation 5 Other (Specify)					
10 Buriel 2 Cremation 3 Removal from State Cargetary, Crematopy or other place) Cargetary, Crematopy or other place) Cargetary, Crematopy or other place)	1-				
1 Buriel 2 Cremation 3 Removel from State Carretary knematopy or other place) Carretary V2/15)	t 21215				
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10 Buriel 2 Cremation 3 Removal from State Cargetary, knematox, or other place) Cargetary, knematox, or other place) Cargetary, knematox, or other place)	ash Are Balto, red liec or respiratory arrest, Approximate				
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10 Burlet 2 Cremation 3 Removal from State Carpetary (crematics, or other place) Carpetary V2/157	Approximate interval Between Onset and Death Death Onset and Death Death Onset and Death Death Onset and Death Dea				
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10 Buttle 2 Cremation 3 Removel from State Carpetary (cametagor other place) Carpetary (73/15)	Approximate interval Between Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset O				
10 Burlet 2 Cremation 3 Removel from State Carpetery (cemetagor other place) Carpetery (24/57)	Approximate interval Between Onset and Daath N. C. M.				
10 Buttle 2 Cremation 3 Removel from State Cargetery (cometogor other place) Cargetery (come	Approximate interval Between Onset and Daath PLE LINE DE PRIORIES LINE DE PRIORIES LINE DE PRIORIES LINE DE PRIORIES LINE DE PRIORIES LINE DE PRIORIES LINE DE PRIORIES LINE DE LINE				
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1 Burfel 2 Ceremation 3 Removal from State Carpetary Prematogo other place) Carpetary Value Va	PERFORMED? 1 YES 2 NO 24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO 24b. WERE AUTOPSY PINDINGS ANALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO 25 NO 26 (Specify) CRIBE HOW INJURY OCCURED ATTON (Street and Number or Rural Route Number, or Town, State) 26(a) and menner as stated. 2 Approximate intravel Between Onset and Daath 2 Approximate intrave				
1 Surfet 2 Gremation 3 Removal from State Composition 5 Compositio	Ilec Dr reapiratory arreat, Ilec Dr reapiratory arreat, Ilec Dr reapiratory arreat, Interval Between Onset and Daath Un Known L manths				
1 Surfel 2 Cremation 3 Removal from State Company from State	PERFORMED? 1 YES 2 NO 24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO 24b. WERE AUTOPSY PINDINGS ANALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO 25 NO 26 (Specify) CRIBE HOW INJURY OCCURED ATTON (Street and Number or Rural Route Number, or Town, State) 26(a) and menner as stated. 2 Approximate intravel Between Onset and Daath 2 Approximate intrave				
100 burlet 2 Cremation 3 Removal from State Carpetgra, termatica, or other place) Camendary V2/15/2 Camendary V2	Ilec Dr reapiratory arreat, Ilec Dr reapiratory arreat, Ilec Dr reapiratory arreat, Interval Between Onset and Daath 2. Approximate in				
10 Burdel 2 Cremation 3 Removed from State Carpetgra, Cremations of Camering V2/15/2 Camering V2/15/	Park Are Balto, Meld Illec Dr reapiratory arreat, Park Balto, Meld Approximate interval Between Onset and Daath Park Land Balto Amanths Amant				
1 Surfel 2 Cremation 3 Removal from State Company from State	Park Are Balto, Meld Illec Dr reapiratory arreat, Park Balto, Meld Approximate interval Between Onset and Daath Park Land Balto Amanths Amant				

Certificate	of Death

Physician
/Medical
Examiner

1. Decedent'a Name (First, Middle, Last) DAVID

S. WILSON JR. 2. Date of Deeth DEC.

3 Time of Death

4a. Facility Name (If not institution, give street and number)
JOHNS HOPKINS HOSPITAL E.R.

6. Sex

4b. City, Town, or Location of Death BALTIMORE

11. 1995 12:31 PM 4c. County of Death

n/a

Yee

Funeral Director

r then "natural", or items 23s or 28s-f show the Medical Experience must be notified at

"natural".

Be

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If them 27 is marked other any injury or other traumatic evant other.

Physician

/Medical

Examiner

sician end buriel-transit

attending physician for use as the burie

the

signed by

has

After !

s efter deeth.

To the Mospital of within 24 hours of To the Funeral Discompletaly filled

filled in by

Hospital or Attending

certificate be executed

Box 68760,

P.O. I

Division of Vital Records.

Examiner

Physician/Medicai

þ 9

Completed

Be

70

Certification:

filed within 72 hours efter all Hygiene.

Faltimore, Maryland 21215-0020

with the Maryland

Usual Residence of Decedent 10a State MARYLAND Directo 912 N.

1**□**₩ 2□ F 10c. City. Town or Location

7. Age (in yrs. last birthday)

Yrs

Mpntha Bays Hours Min. 0 (Month Pey 1995)

9. Birthpiace (State or Foreign BACTIMORE, MD

10b. County n/a

baltimore

10d. Inside City Limits XX Yes 2 □ No

Day

10e. Street and Number

5. Sociel Security Number

216-45-6801

BRADFORD 11 Maritai Status

STREET

10f. Zip Code 21205 10g. Citizen of What Country? UNITED STHIES

1 Never Merried 2 Married 3 ☐ Widowed 4 ☐ Divorced

12. Wes Decedent Ever in U,S. Armed Forces?
1 ☐ Yes XX No Year or Dates

 Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes XX No Specify:

14 Race - American Indian Black, White, etc.

15. Decedent's Education (Specify only highest grede completed)

Coilege (1-4or 5+)

16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired)

Specify: BLACK 16b. Kind of Business/Industry

Elementery/Secondary (0-12)

np

BABY

na

17. Father's Name (First, Middle, Last)

DAVID SHERRON WILSON JR. Sr.

18. Mother's Name (First, Middle, Maiden Sumeme)

CARLITA PINDFIL

19e. Informant's Name/Reletionship (Type, Print)

WILSON SR. 912

19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code)

21205

Approximate Interval Between Onaet end Death

DAVID SHERRON

20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State

20b. Place of Disposition (Neme of cemetery, cremetory or other piece)

BRADFORD STREET, BALTIMORE, MD 20c. Location - City or Town, Stete

4 ☐ Donetion 5 ☐ Other (Specify)

VOSHELL MEMOR I AL

Ν.

GARDENS 12-15

21. Signature of Funeral Service Licensee,

22. Name and Address of Fecility

WM. C. MARCH FH.-1101 E. NORTH

Put 1. Enter the disease, or complications the death. Do not entar the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line.

SUDDEN INFALT DEATH SYNDROME Due to (or as e consequence of):

tmmediete Ceuse (Final disease or condition resulting in death)

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in deeth) Last

Due to (or as a consequence of)

Due to (or es e consequence of)

Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco usa contribute to the cause of death? 1 Yas 2 No 3 Probably 4 Unknown

24e. Was en autopsy performed?

24b. Were autopsy findings available prior to completion of cause of death?

Nes 2 No 26. Piece of Deeth (Check only one)

1 Yes 2 No

25. Was case referred to medical examiner?

Yes 2 No

27. Menner of Death

1 Natural

2 Accident

4 Homicide

3 ☐ Suicide

5 Pending investigation

6 Could not be determined

28a. Dete of Injury (Month, Dey Year)

28c. Injury at Work? 1 Yes 2 No

Other: 4 Nursing Home 5 Residence 8 Other (Specify) 28d. Describe how injury occurred

28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a, Certifier (Check only 1 Certifying Phyatotan: To the best of my knowledge, death occurred at the time, dete and place, and due to the cause(s) and manner as stated.

**Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end piece, end due to the cause(s) end menner stated.

29b. Signature and title of certifier

29c. License number O.C.M.E

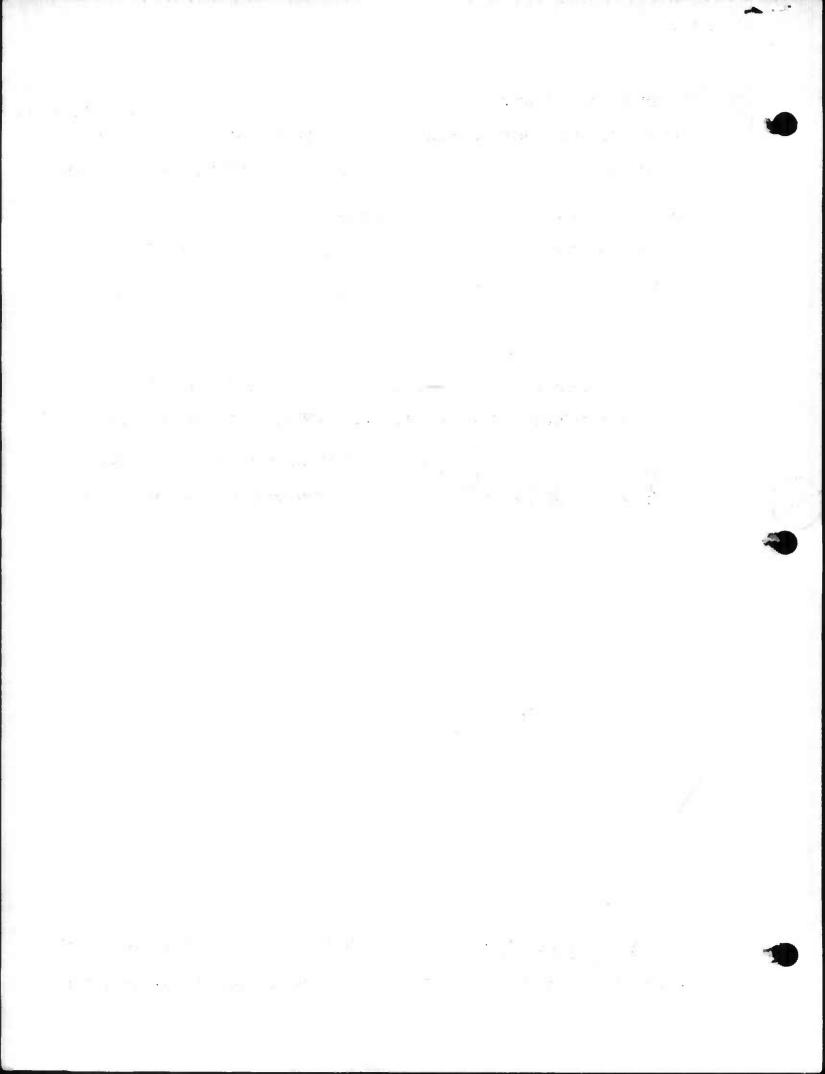
29d. Date signed (Month, Day, Year) DECEMBER 12,1995

NO 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

HARRANITO Wolen Will Penn Street, Baltimore, Maryland 21201

State Registrar

32. Registrar's Signature 31. Dete filed (Month, Dey, Year) 5 1995 DEC 1



REG. NO

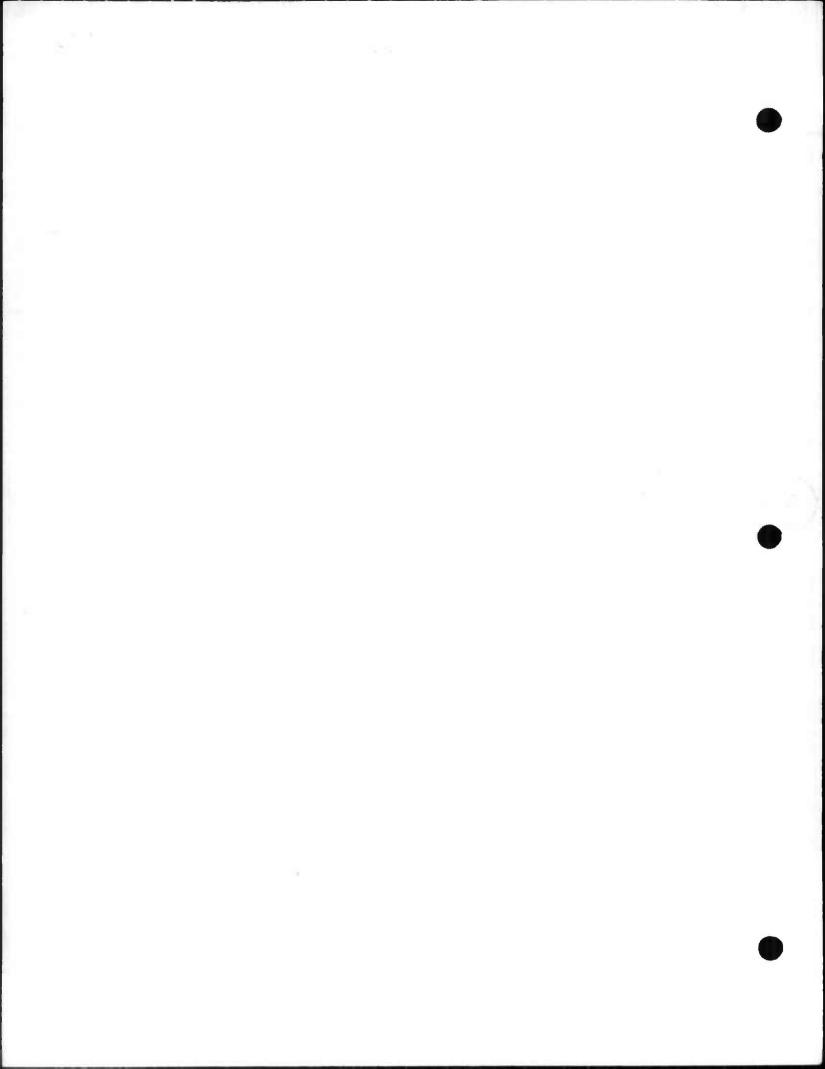
STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

PALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

1. DECEDENT'S NAME (First, Middle, Last 2. DATE OF DEATH MONTH 3. TIME OF DEATH Vright Albert 4:14 December 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. lest birthday) 7. DATE OF BIRTH (Month, Day, Year) 04 - 29 -IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or For 3 1 M 2 YRS Pages 1, 2, 3 should 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR GEORGE EDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY NONE 1 YES 2 HO permit. 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE WHAT COUNTRY more the burial-transit retained by the hospital or attending physician. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 14. RACE — American Indian, Black, White, alc. 1 💹 Never Married 2 🗌 Married Black BY 3 Widowed 4 Divorced use as 1 60 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)

SECURITY 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only high ᇤ è Elementary/Secondary (0-12) College (1-4 or 5 +) COMPL UNKNOWN funeral director, page 5 should be detached once. 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle notified at 19a, INFORMANT'S NAME (Type/Print) 2 Page 6 may be must be 20a. METHOD OF DISPOSITION
1 M Burlal 2 Cremation 3 D F 20b. PLACE AND DATE OF DISPOSITION /No 4 Donation 8 C Other (Specify) traumatic event, the medical examiner 21. SIGNATURE OF FUNERAL SERVICE Home THE DERRICK hours after death. ysician and completely filled in by the prior to burial, cremation, or removal. 23. PART I. Enter the diseases, or complications that ceused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, ahock, or heart fellure. List only one ceuse on each line Interval Between **IMMEDIATE CAUSE (Finel Onset and Death** RESPIRATORY FAILURE due to PNEUMOANIA disease or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF) MYCOBACTERIUM avium-Intracellulare CERTIFICATION Sequentially list conditions, if any, leading to immediate been signed by the attending physician of. of Health and Mental Hygiene prior to Indome urred Immun ode cause. Enter UNDERLYING COMCL CAUSE (Disease or Injury QUE TO (OR AS A CONSEQUENCE OF) that initiated events nelnom Stino resulting in death) LAST injury, or PART II. Other algnificent conditions contributing to deeth but not resi MEDICAL erlying ceuse given in Part I. 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE 24s. WAS AN AUTOPSY shows any 1 YES 2 1 NO OF DEATH? t YES 2 NO PHYSICIAN: DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN OR ATTENDING PHYSICIAN: The law this certificate has be with the State Dept. Item 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) NO 1 YES 2 atlant 2 ER/Outp 4 Nursing Home 5 Residence 8 Other (Specify) 6 27. MANNER OF DEATH 28a. DATE OF INJURY 28c. INJURY AT marked. 26d. DESCRIBE HOW INJURY OCCURED M t YES 2 NO After death BY Accident 3 Suicide 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) TO THE HOSPITAL OR ATTENDING TO THE FUNERAL DIRECTOR: AI be filed within 72 hours after de IMPORTANT: If item 28 Is 6 Could not be 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) item 28 Is COMPLETED 4 Homicide determined 29a. CERTIFIER 1 SCERTIFYING PHYSICIAN: To the best of my knowledge, dasth occurred at the time, data and placa, and due to the cause(a) and menner as stated. (Check only one) 2 MEDICAL EXAMINER: On the basis of exa mination and/or investigation, in my opinion, death occured at the time, data and placa, and dua to the cause(a) and menner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER BE 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) Getacher 280 9 WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MARYLAND HOUSE OF CORRECTION-31. DATE FILED (MONTH, Day, Year) 32/AEGISTHAR'S SIGNATURE 1995



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Heatth and Merital Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be netified at once. DIVISION OF VITAL RECORDS, P.O. BOX 68760

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

	1. DECEDENT'S NAME (First	, Middle, Last)	Ben jam:	in Keic	er Wi	llia	me 1	TT		2. DATE OF	DEATH			3. TIME OF DEATN
	- Bea Te		Kurty.		W-		1115 1			MONTH 12	/ 04	7 /10	YEAR S	10:70 A M
	4. SOCIAL SECURITY NUME	BER	5. SEX	8. AGE (In yrs.		1	R 1 YEAR	IE IMPE	R 24 HRS.	7. DATE OF	BIDTH	8. BIRTHPLACE (State or Foreign		
	214-76-5		1 🕅 M 2 🗆 F	37	YRS.	MONTHS	DAYS	HOURS	MIN.	DEC 1	mr Vinnel	58	Counti	yland (
	9a. FACILITY NAME (If not in	natitution, give s	treet and number)			9b. CITY, TOWN OR LOCATION OF DEATN					9c. COUNTY OF DEATN			
DIRECTOR	1440 Gilbe		d			Aı	cnol	d				Anne Arundel		
Ĕ	10a. STATE	10b. COUNTY	7		10c. CIT	CITY, TOWN OR LOCATION 16d. II					10d. INSIDE CITY			
	Maryland 100, STREET AND NUMBER		Arunde1						nold			LIMITS?		
FUNERAL	1440 Gilbe:		d			101. ZIP CODE 21012						10g. CIT	USA	VHAT COUNTRY?
5	11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARI				ARMED	13.	WAS DE	CENDENT (OF HISPAN	IC ORIGIN? (S	Decify Yes	or No-	14. BACE	- American Indian,
B	1 Never Married 2 X 3 Widowed 4 Divo		IF YES, GIVE W	A YES 2 [MAR OR DATES - 1983	NO	If yes, specify Guban, Mexican, Puarto Rican, atc.) Black, W					white, etc. White			
요	15. DEC	EDENT'S EDUC y highest grade	CATION	16a.	DECEDENT'S	USUAL C	CCUPATI	ON		16b. KIN	ND OF BUS	SINESS/IN	DUSTRY	
COMPLETE	Elementary/Secondary (0		College (1-4 or 5 -	-1	(Give kind of life. Do NOT u Ver	Ind of work done during most of working NOT use retired.)				at C1	eani	ng		
O	17. FATHER'S NAME (First, M							18. MOT	HER'S NAI	ME (First, Midd			0	
BEO			. William							Clari				llum
6	190. INFORMANT'S NAME (Type/Print) Halya Lauber Williams 71					Jarv	s (Street 715 l	end Number Rd. S	or Aural A Saras	ota, I	City or Town	n, State, Zi 241	p Code)	
İ	20e. METHOD OF DISPOSIT 1	on 3 🗌 Reme	oval from State		Semerate				12/1	3/95			ore,	
	21. SIGNATURE OF FUNERA	L SERVICE LIC	Dawn	F. McD	onald	يهم (NAME A	ND-ADDRE	SS-OF FAC	ety of	f Mar	v1 ar	nd T	nc
	- Waw	Mil	1º Hon	ald		29	99 F	redei	cick	Rd. Ba	altin	nore,	MD	21228
- 1	23. PART . Enter the di shock, or h	iseeses, or c eart fellure. I	complications the List only one ceu	t coused the	deeth. Do i	not enter	r the mo	ode of dy	ing, such	ss cerdlec	or respi	ratory sr	rest,	Approximats Interval Between
	IMMEDIATE CAUSE (Fir disesse or condition	nal	-	ver F	A									Onset and Death
	resulting in desth)	→ ,	B											Few weeks
_	DUE TO (OR AS A CONSEQUENCE OF): H c 2 a tom-													
ģ	Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF):													
3	cause. Enter UNDERLY!	ING	C	irrhos										few years
CERTIFICATION	that initiated events		DUE TO	(OR AS A CONS	EOUENCE O	F):								
H H	resulting in desth) LAS		i											
- 11	PART II. Other algnifice	nt condition	s contributing to	death but not	t resulting	in the u	nderlyln	g ceuse	given in i	Part I. 24	n. WAS AN	AUTOPSY	24b.	WERE AUTOPSY FINDINGS
2 E											PERFOR	1		AMAILABLE PRIOR TO COMPLETION DF CAUSE
NED!								-	-	_ ''	YES 2	DO NO		OF DEATH?
Σ	DID TOBACCO U	SE CONTR	RIBUTE TO CA	USE OF DE	ATH YE	S 🗆	NO D	L UNC	ERTAIN					T TES 2 NO
Z I	25. WAS CASE REFERRED TO EXAMINER?				ACE OF DEA									
2	1 TYES 2 NO		HOSPITAL:	ER/Outpatient	3 DOA	OTHE!		no 5 Re	ssidence (B ☐ Other (Sp	pecify)			
PHYSICIAN:		Pending	28a. DATE OF (Month, D		28b. TIM	E OF URY M	WC	JURY AT ORK?	NO.	26d. DESCRI	BE HOW IN	JURY OC	CURED	
ED BY	3 Suicide 8	Could not be	28e. PLACE O building,	F INJURY — At atc. (Specify)	home, tarm,	street, tac				28t. LOCATIO City or To	ON (Street a	nd Numbe	or Rural R	oute Number,
<u> </u>							-							
COMPLETED	(Check only		CIAN: To the best of R: On the basis of ex											and manner as stated.
	29b. SIGNATURE AND TITLE	OF CERTIFIER						29c. LICI	ENSE NUM	BER		29d. DAT	E SIGNED	(Month, Day, Year)
2		mi	MY					b	723	S			12/1	2/95
-	Bahadur M	PERSON WHO					L	Mus	4 16 -	d Hor	1.1.	1	To be	rnal medicini
	31. DATE FILED (Month, Day,	-		R'S SIGNATURE	2.1	<u>، د</u>		(4	1 1000	. ,, - 3	(110	`	24.6	-ca) CIMI
	DEC 1 5 199	15 Jul	32. REGISTRA	Translath										

a reference de co

 Page 6 may be retained by the hospital or attending physician.
 ment director, page 5 should be detached for use as the bunial-transit permit. Pages 1, 2, 3 should SALTIMORE, MARYLAND 21215-0020 TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed without a law and the first of any be retained by the attending physician and completed that the first of a first of a first of the state of the first of th

DIVISION OF VITAL RECORDS, P.O. BOX 68760

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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAR		CERTIF	ICATE OF	DEATH	REG.	NO.			
	t. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH	DAY	YEAR	3. TIME OF DEATN	
	JEAN	WISSOFF				DEC. 5	, 1995		8:25 A M	
	4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE	E (In yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year			IPLACE (State or Foreign	
	055-09-1897	1 🗆 M 2 🔀 F	86 YRS.	MONTHS DAYS	HOURS MIN.	JAN. 25	,1909	NEV	W YORK	
DIRECTOR	98. FACILITY NAME (If not institution, give s NORTH OAKS NURSI RESIDENCE OF DECEDENT			BALTIM	ORE	EATH		ALTI		
EC	10a. STATE 10b. COUNT			10c. CITY, TOWN OR LOCATION 16d. INSIDE						
		IMORE	BA	LTIMORE			LIMITS? 1 YES 2			
FUNERAL	725 MT. WILSON			101	21208			U.S.A	A.	
BY	11. MARITAL STATUS 1 Never Married 2 Married 3 Wildowed 4 Divorced	12. WAS DECEDENT EVER FORCES? 1 YES	S 2 NO	2 NO If yes, specify Cuben, Maxican, Puerio Rican, etc.)					E — American Indian, k, Whita, atc. hy: WHITE	
ED	15. DECEDENT'S EDU (Specify only highest grade	ICATION a completed)		USUAL OCCUPATION		16b. KIND OF	BUSINESS/IN	DUSTRY		
	Elementary/Secondary (0-12)	College (t-4 or 5+)	life. Do NOT u	se retired.)	or working					
MPI	12th.		SECRET	ARY		INSU	RANCE			
COMPLETED	17. FATNER'S NAME (First, Middle, Last)	WISSOFF				ME (First, Middle, Mai				
BE	SOLOMON 19a. INFORMANT'S NAME (Type/Print)	10h MAII IN	Annece (Cimal		BECCA Route Number, City or		EPLO	N		
5	DR.SHELDON KRAVI	TZ				NUE, BALT			09	
	20a, METHOD OF DISPOSITION 1 METHOD OF DISPOSITION 3 METHOD OF DISPOSITION 3 METHOD OF DISPOSITION 3 METHOD OF DISPOSITION			CE AND DATE OF DISPOSITION (Name of cramatory or other place) DATE 20c. LOCATION — City or Town, State						
	4 Donation 5 Other (Specify)		MT_HEBRON		ND ADDRESS OF FA	2/07/95	FLUS	HING	NEW YORK	
	A who ?	n. Citt	1	SOL	LEVINSON	& BROS.			01015	
	23. PART i. Enter the diseases, or	complications that caus	sed the death. Do			TOWN RD.			21215	
		List only one cause on	each line.						Interval Between Onset and Death	
	immediate dade (Final									
	disease or condition resulting in death) a. Renal Failure Due to (or AS A CONSEQUENCE OF):									
z	LACK OF ORAL INTAKE									
9	Sequentially list conditions, If any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF):									
S	CAUSE (Disease printury									
CERTIFICATION	that initiated events resulting in deeth) LAST	DUE TO (OR AS	A CONSEQUENCE O	NF):						
E I		d								
DICAL (PART II. Other algnificent condition		but not resulting	in the underlyin	g cause given in		S AN AUTOPSY	240	. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO	
20	Decubitis	vler				t 🗆 YE	S 2 NO		COMPLETION DF CAUSE OF DEATH?	
ME									1 - YES 2 - NO	
ÿ	DID TOBACCO USE CONT	RIBUTE TO CAUSE				N 🗆				
PHYSICIAN: M	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:		OTHER:						
ΥS	1 YES 2 NO	t inpatient 2 ER/O		4 Li Nursing Non		8 Other (Specify)				
	27. MANNER OF DEATN t Netural 5 Pending	28a. DATE OF INJUR (Month, Day, Year		JURY WO	JURY AT DRK?	28d. DESCRIBE NO	W INJURY O	CCURED		
BY	2 Accident Investigation	200 DI ACE OF IN HI	RY — At home, ferm,		YES 2 NO	004 4 004 7100 400				
TED	3 Suicide 6 Could not be 4 Nomicide determined	building, atc. (S)		street, factory, onto	•	281. LOCATION (Street and Number or Rural Route Number, City or Town, State)				
	29a. CERTIFIER DESTINATION PROPERTY	SICIAN: To the beat of my kno	owledge death occur	rad at the time, date	and place, and due	to the source(s) and		nt and		
COMPLET	Time N	ER: On the basis of examinat							s) and manner ea steted.	
9	291L SIGNATURE AND TITLE OF CERTIFIE	R			29c. LICENSE NU	MBER	29d. DA	TE SIGNE	(Month, Day, Year)	
品	Muli	MP			D386		•	1215	1 -	
2	30 NAME AND ADDRESS OF PERSON WI		DEATN (ITEM 27) (Typ	e, Print)	,,,,			, -, 1,		
	JOEL MESHI			NER ST	BACT	MP	212	30		
	DEC 15 1995	32 REGISTRAR'S SH	GNATURE							

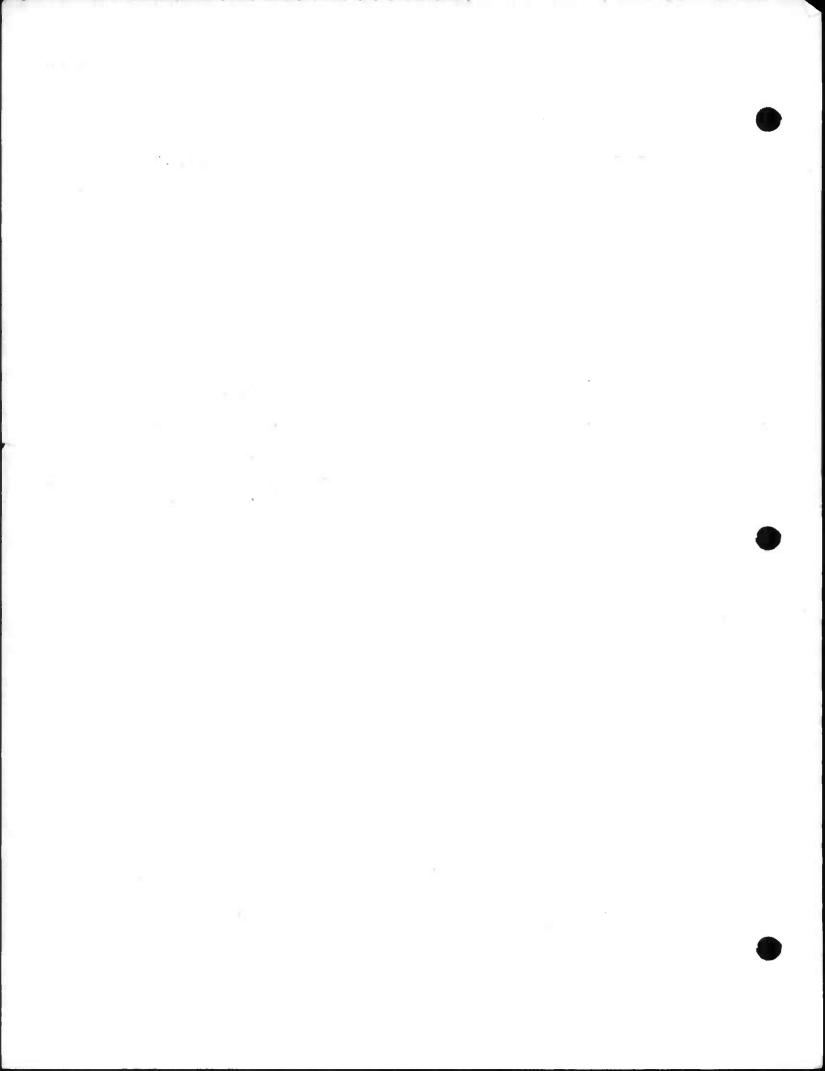
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

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IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

-	HEGISTHAN				OATE	<u> </u>	LAIII	<u> </u>	REG. NO.			
	1. DECEDENT'S NAME (First, Mide	, ,							DATE OF DEATH	NY.	YEAR :	3. TIME OF DEATH
- 1	ALBERTA	MARYLAND	APP	ELLA					DEC. 12			9:55 PM
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. last	birthday)	IF UNDER 1 Y		F UNDER 24 H		DATE OF BIRTH (Month, Day, Year)	\neg	8. BIRTHPI Country)	LACE (State or Foreign
- 6	214-24-9773	1 🗆 M 2 📈 F	87	YRS.	MONTHS	MYS F	IOURIS M			1908		
	9a. FACILITY NAME (If not instituti				96. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DE					TY OF DE	ATH	
8	Stella Mari				Tou	uson				Bal	timo	re
5	RESIDENCE OF DECED											
DIRECTOR					, TOWN OR	LOCATIO		D 0 4			1	IOd. INSIDE CITY LIMITS? I XYES 2 NO
9	Maryland 100. STREET AND NUMBER	N/A						Balt	imore Ci			
FUNERAL	3939 Roland	4				10f, Z	IP CODE		4.0			IAT COUNTRY?
												States
5	11. MARITAL STATUS 1 Never Married 2 Marr		T EVER IN U.S. ARI	NAMED 13. WAS DECENDENT OF HISPANIC NO If yee, specify Cuben, Mexican, I				ISPANIC O	PRIGIN? (Specify Yes Jerto Rican, etc.)	or No-	14. RACE - Black,	- American Indian, White, etc.
B	3 Widowed 4 Divorced	AR OR DATES							Specify:	White		
	15. DECEDEN	NT'S EDUCATION	16a DEC	PENENT'S	USUAL OCCU	IDATION			400 8000 00 000			WILLE
	(Specify only high	hest grade completed)	(Gh	ve kind of w	ork done duri	ing most	of working		16b. KIND OF BUS	SINESS/INDI	USTRY	
2	Elementary/Secondary (0-12) 8 Years	College (1-4 or 5 d	+)			har			00-4			
COMPLETED	17. FATHER'S NAME (First, Middle,	Lest)		Un	ressmo			C NAME /	CLOT			
	Martin Luthe	,				_						
띪	19a. INFORMANT'S NAME (Type/P	rint)	196	MAILING	ADDRESS (C	tmat and	Saar	e El	izabeth Number, City or Town	<u>Hende</u>	rson	
2	Rosalie E. 1		190									1000
			20b. PLACEA						d Dunda	CATION - C	1V Z	1222
	20a, METHOD OF DISPOSITION 1 Burlal 2 Cremation 3 4 Donation 5 Other (Special Control of Control		cemetery, cren	netory or off	per plece)	+ A L	. 10/	1 - /1	995 Gl	CATION — C	ity or low	n, Stata
	21. SKINATURE OF FUNEBAL SE		Control	THE CO	22. NAI	ME AND	ADDRESS O	DF FACILIT	795 GL	en bu	rnie	MU
- 1	»/ ///	1/2/-	2/	/	Dua	la-Ri	ick F	uner	al Home	of Du	ndal	k. Inc.
_	(MM	11 - 1.	war.	_	792	2 W.	ise A	vo.	Dundalk	. MD	212	22
1	23. PART I. Enter the disease shock, or heert	ses, or complications that fallure. List only one ceu	t caused the dea se on each line.	ith. Do no	ot enter the	e mode	ot dying,	such ss	cardisc or respi	ratory erro	est,	Approximats interval Between
- 1	IMMEDIATE CAUSE (Final											Onset and Desth
	disesse or condition resulting in desth)	e. PNEUMO										
1	DUE TO (OR AS A CONSEQUENCE OF):											
8	Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF):											
F	If any, leeding to immediate cause. Enter UNDERLYING	DOE 10	(OH AS A CONSEC	DENCE OF):							
CERTIFICATION	CAUSE (Disesse or Injury that initiated events	C. DUE TO	(OR AS A CONSEO	UENCE OF).							
	resulting in death) LAST				,							j l
E I		d										+
4	PART II. Other significent co	onditions contributing to	deeth but not re	sulting in	the unde	rlyIng c	ause give	n In Part	I. 24s. WAS AN PERFOR			VERE AUTOPSY FINDINGS
EDICAL									1 TES 2	100	c	OMPLETION OF CAUSE OF DEATH?
ME										C.		YES 2 NO
	DID TOBACCO USE	CONTRIBUTE TO CA	USE OF DEAT	H_YE	S NO		UNCERT	TAIN D	8			
S	25. WAS CASE REFERRED TO ME EXAMINER?			OF DEATH	H (Check rint)							
PHYSICIAN:	1 TES 2 00	1 [] Inpetient 2 []	ER/Outpetent 3	DOA	Nursing	Home	5 🗆 Resider	nce 6 🗆	Other (Specify)			
E I	27. MANNER OF DEATH	28s. DATE OF (Month, Di	INJURY /	280 TIME INJU		c. INJUR WORK		284	DESCRIBE HOW IN	JURY OCC	URED	
B	1 Natural 5 Pend 2 Accident Invest	tigation		/			2 [] NO) .				
	3 Suicide 5 Coult	building.	F INJURY — At you etc. (Specify)	ne, farm, so	reet, factory,	office		291.	LOCATION (Street at City or Town, State)	nd Number o	or Hural Nov	fir Number
Ë L	4 Humicide deter	mined										
2 1	29a. CERTIFIER CERTIFYIN	G PHYSICIAN: To the best of	my knowledge, dee	th occurred	d at the time.	date an	f place, and	due to the	e cause(s) and man	ner as state	d.	
COMPLETED		EXAMINER: On the besis of as										nd menner as stated.
Ö	295. SIGNATURE AND TITLE OF C		_		>		e ascanse		/			form, Day_Year)
<u>∞</u> ∥						- 1	1/13	, 28	4		2 1	3. 95
유	30. NAME AND ADDRESS OF PER	SON WHO COMPLETED CAUS	E OF DEATH (ITEM	27) (Type, I	Print)		100			55		
	EDDIE NAKHUDA		DULANEY			D T	COWSO	N, M	D 21204			
	31. DATE FILED (Month, Day, Year)					-						
	DEC 1 8 1995	The Dancison	MANAGEM									



	1. DECEDENT'S NAME (First, Mide	Me, Lest)						REG. NO DATE OF DEATH		3. TIME OF DEATH	
1	GEORGE R. B	EYER					100	EC 16	199	8:00 P M	
	4. SOCIAL SECURITY NUMBER	s. sex	in message dec	inst birthday)	FUNDER 1 TEX	THE RESERVE AND ADDRESS OF THE PERSON NAMED IN	The state of the s	DATE OF BIRTH (Month, Day, War)		BIRTHPLACE (State or Foreign Country)	
	212-24-8537	1√ M 2 □ 1	81	YRS.	SCHOOL CON	A HOURS		AN 13	and the second	MARYLAND	
œ	Be. FACILITY NAME (If not institute	ion, give street and number)			9b. CITY, TOW	WN OR LOCATI	ON OF DEATH	6	St. COUNTY	OF DEATH	
ривестоя	HARBOR HOSPIT	AL			BALT	IMORE	CITY		N/A	A	
REC	10s. STATE 10b	COUNTY		18c, CIT	Y, TOWN OR LO	CATION				16d. INSIDE CITY LIMITS?	
1.5		NNE ARUNDEL		BRO	OKLYN					1 ☐ YES 3 🔀 NO	
RAL	104. STREET AND NUMBER					101. ZIP CODE	E		19g. CITIZES	OF WHAT COUNTRY?	
FUNERAL	8 14TH AVE.	12. WAS DECED	SENT-EVER IN U.S.	ARMED		21225	W MERCHANIC C	ORIGIN7 (Specify Yes	USA		
3 Wildowed 4 Divorced IF YES, GIVE WAR ON DATES				NO	If yes		n, Mesican, Ps	uerto Rican, etc.)			
TED	IS. DECEDES (Specify only high	KT'S EDUCATION test grade cumpleted)	16a	(Giver kind of	USUAL OCCUP		10	166, KIND OF BUI	SINESS/INDUS	THY	
LET	Elementary/Secondary (0-12)	College (1-4 or	5+)	the Do NOT u	se retired.)			MARIN JAIMAN DAN			
COMPL	17, FATHER'S NAME (First, Middle	Lesp		TRUCK	DRIVE	Oh house	MEDIC MANUE	BALTIMO		TY.	
	JOHN CHARLES	asaan ann v				0.000	Y MORE		Surmerie)		
) BE	19s. INFORMANT'S NAME (Type/F)	And the state of t		19b. MAILING	ADDRESS /Str			Mumber, City or Tow	m, Share, Zip Co	dej	
5	MARY TERESA BE		1	8 14	TH AVE	. BROO	KLYN.	ID 21225			
	20s. METHOD OF DISPOSITION 1/Δ Burlel 2 □ Cremetion 3	☐ Removel from State	contrates.	white and delivery that is	OF DISPOSITION		200			or Town, State	
	4 □ Donation 5 □ Ottyn floor 21. SIGNATURE OF FUNERAL SEI		CROW	NSVILL	-	-			VNSVILI	LE, MD	
	. //	1/			RAYM	OND C.	FINK	FUNERAL	HOME		
	- Jan	n/10	1		426	CRAIN	HWY SV	V GLEN BU	URNIE, N	MD 21061	
	23. PART I. Enter the disease shock, or heart	ses or complication of failure. List only only of	het ceused the suse on each	ilne.	not enter the	mode of dy	ing, auch as	cerdiac or reap	iratory srrest	Approximats Interval Between	
	IMMEDIATE CAUSE (Finel disease or condition		/	1	111	-		D	1.	Onset and Death	
	resulting in desth)		TO (OR AS A CON	ISEQUENCE O	14000 th L	CA	ncer	of Re	ctum.	140	
z	2 - V		Lonn	tic	Luile	ne 2	al 1	he Com	wh-	/mo	
RTIFICATION	Sequentially list conditiona, if any, leeding to immediate		TO OR AS A CON	SEQUENCE 9	h: /	-				(1)	
100	cause. Enter UNDERLYING CAUSE (Disease or Injury	C. DUE	TO (OR AS A CON	As Isl	n fen	Sun				10905	
E	that initieted eventa resulting in death) LAST	1	TO (ON AS A CON	SEGDENCE O	r) .						
S		d									
CAL	PART ii. Other significent co	onditions contributing	to death but n	ot resulting	in the underi	ying cause (given in Pari	t i. 24a. WAS AN PERFOR		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO	
= 1								1 TYES 2	No	OF DEATN?	
	DID TOD (000) 100	CONTRIBUTE TO						-		1 TES 2 NO	
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A	DID TOBACCO USE (25. WAS CASE REFERRED TO ME				S NO		ERTAIN L	-		<u> </u>	
SICIAN:		DICAL HOSPITAL:		LACE OF DEA	TN (Check only o	nne)					
SICIAN:	25. WAS CASE REFERRED TO ME EXAMINER? 1 VES 2 NO 27. MANNER OF DEATH	DICAL HOSPITAL: 1 Inpetient 28e. DATE	26. P 2 ER/Outpatien OF INJURY	LACE OF DEA	OTHER: 4 Nursing to 18c.	Nome 5 Re	sidence 8 🗆	Other (Specify)	NJURY OCCUR	ED	
PHYSICIAN:	25. WAS CASE REFERRED TO ME EXAMINER? 1 VES 2 NO 27. MANNER OF DEATH 1 Notural 5 Pend	DICAL HOSPITAL: 1 Inpetient 28e. DATE	26. P	LACE OF DEA	OTHER: 4 Nursing to E OF 28c.	Nome 5 - Re	sidence 8 🗆	Other (Specify)	NJURY OCCUR	IED .	
D BY PHYSICIAN:	25. WAS CASE REFERRED TO ME EXAMINER? 1 VES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pend 2 Accident Invest 3 Suicide 8 Coulc	DICAL HOSPITAL: 1 Inpetient 28e. DATE (Month tigetion d not be 28e. PLAC	26. P 2 ER/Outpatien OF INJURY	DACE OF DEA	OTHER: 4 Nursing P E OF 28c.	Nome 5 Re INJURY AT WORK? YES 2	sidence 8 🗆 28d	Other (Specify)	and Number or		
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ETED BY PHYSICIAN:	25. WAS CASE REFERRED TO ME EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pend Invest 2 Accident 1 Could deten 4 Nomicide 8 Could deten 29e. CERTIFIER (Check only 1	HOSPITAL: 1 Inpetient 28e. DATE (Month tigstion d not be mined 38e. PLACI building 46 PHYSICIAN: To the best	26. P 2 ☐ ER/Outpatien OF INJURY , Day, Year) E OF INJURY — A ng, etc. (Specify) of my knowledge	28b. TIM 1 home, ferm,	OTHER: 4 Nursing N E OF 28c. URY M 1[street, fectory, co	Nome 5 Reinjury AT WORK? YES 2 Miller	286 NO 286	Other (Specify) d. DESCRIBE NOW I LOCATION (Street City or Town, State)	and Number or i	Rural Route Number,	
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BE COMPLETED BY PHYSICIAN:	25. WAS CASE REFERRED TO ME EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pend Invest 2 Accident 1 Could deten 4 Nomicide 8 Could deten 29e. CERTIFIER (Check only 1	DICAL HOSPITAL: 1 Inpetient 28e. DATE (Month d not be mined) 128e. PLACI buildit 28e. 6. P 2 ☐ ER/Outpatien OF INJURY , Day, Year) E OF INJURY — A ng, etc. (Specify) of my knowledge	28b. TIM 1 home, ferm,	OTHER: 4 Nursing N E OF 28c. URY M 1[street, fectory, co	Nome 5 Reinjury AT WORK? YES 2 Office	286 NO 286	Other (Specify) d. DESCRIBE NOW I L. LOCATION (Street City or Town, State) the cause(e) and mar d, date and place, an	and Number or i	Rural Route Number, euse(e) and manner ee stated. IGNED (Month, Day, Year)		
COMPLETED BY PHYSICIAN:	25. WAS CASE REFERRED TO ME EXAMINER? 1	HOSPITAL: 1 Inpetient 28e. DATE (Month tiggition d not be mined 28e. PLACI buildit RG PHYSICIAN: To the best EXAMINER: On the basic of	26. P 2 □ ER/Outpatien OF INJURY . Day, Year) E OF INJURY — A ng, etc. (Specify) of my knowledge of examination end	LACE OF DEA	TN (Check only & OTHER: 4 Nursing t E OF 28c. URY M 1 street, fectory, c and at the time, c on, in my opinio	Nome 5 Reinjury AT WORK? YES 2 Office	NO 28f	Other (Specify) d. DESCRIBE NOW I L. LOCATION (Street City or Town, State) the cause(e) and mar d, date and place, an	and Number or i	Rural Route Number,	
O BE COMPLETED BY PHYSICIAN:	25. WAS CASE REFERRED TO ME EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pend 2 Accident Invest 3 Suicide 8 Coulk defence (Check only one) 29b. SONATURE AND TITLE OF C	HOSPITAL: 1 Inpetient 1 Inpetient 28e. DATE (Month And PHYSICIAN: To the best EXAMINER: On the basic of BERTIFIER	26. P 2 □ ER/Outpatien OF INJURY . Day, Year) E OF INJURY — A ng, etc. (Specify) of my knowledge of examination end	LACE OF DEA	TN (Check only & OTHER: 4 Nursing t E OF 28c. URY M 1 street, fectory, c and at the time, c on, in my opinio	Nome 5 Reinjury AT WORK? YES 2 Office	NO 28f	Other (Specify) d. DESCRIBE NOW I L. LOCATION (Street City or Town, State) the cause(e) and mar d, date and place, an	and Number or i	Rural Route Number, euse(e) and manner ee stated. IGNED (Month, Day, Year)	

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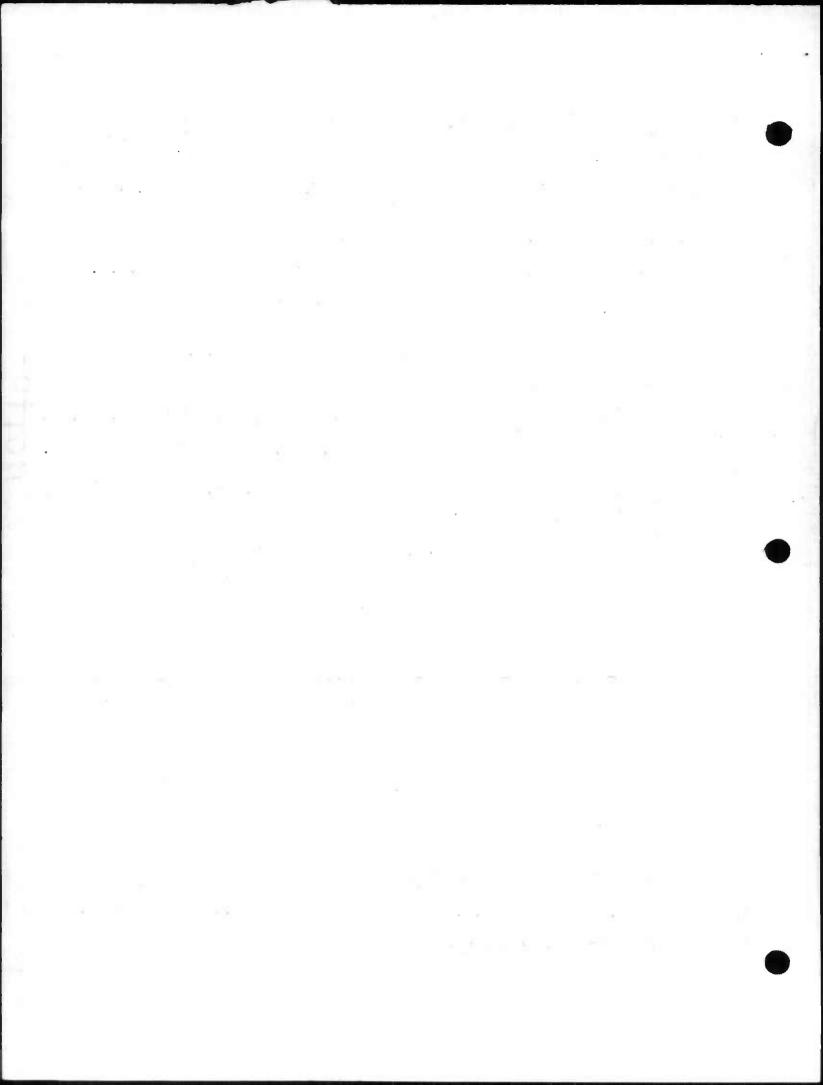
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attending physician.	use as the burial-transit pu		
TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 74 hours after death. Page 6 may be retained by the hospital or attending physician.	TOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit pen		IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
rs after death. Page 6 r	n by the funeral director	removal.	dical examiner mu
xecuted within 24 hour	and completely filled in	be filed within 72 hours after death with the state Dept. of Health and Merital Hyglene prior to build, cremation, or removal.	latic event, the me
death certificate be e	e attending physician	nertal rygiene prior to	ury, or other traum
e law requires that the	has been signed by th	Dept. of Health and N	1 23 shows any inj
NDING PHYSICIAN: Th	l. After this certificate	r death with the State	is marked, or item
E HOSPITAL DR ATTEI	E FUNERAL DIRECTOR	d within 72 hours after	RTANT: If item 28
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	FOR	STATE OF MARYLA	ND / DEPAR	TMENT OF H	IFAITH AND	MENTAL HYGIEN	F	, .	,011.
,	- STATE REGISTRAR 1. DECEDENT'S NAME (First, Middle, Last)	R	CERTIF	ICATE OF	DEATH	REG. NO.	NY CO		3. TIME OF DEATH
	Zelda			Bv		Lec	13	।विवेड	4.20A M
	027-09-3063	t □ M 2 X F 84	yrs. last birthday) YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS.	J. (Mothery Day, 264)		Mas	sachusett
E CH	90. FACILITY NAME (If not institution, give stree Suburban Hospita			Bethe	sda	EATH		tgoi	mery
FUNERAL DIRECTOR	10a. STATE 10b. COUNTY			Y, TOWN OR LOCA					10d. INSIDE CITY LIMITS?
3	Maryland Monte	gomery	Sil	Lver Sp	ring				1 X YES 2 NO
2				10					HAT COUNTRY?
ž.	2410 Dexter Aver	LU C			20902			U.S	
	1 Never Merried 2 Married 3 Widowed 4 Divorced	FORCES? 1 TYES IF YES, GIVE WAR OR DAT	2 VNO	If yes, sp		NNC ORIGIN? (Specify Yes or No— 14. RACE — American Indian, Black, Whita, atc. 19: White			
3	15. DECEDENT'S EDUCA		16a. DECEDENT'S	USUAL OCCUPATI	ON	16b. KIND OF BU	SINESS/IND		
COMPLEIED	(Specify only highest grade or Elamentary/Secondary (0-12)	College (1-4 or 5+)	ACCOUI		ost of working	U.S.	Gov	ern	ment
	17. FATHER'S NAME (First, Middle, Last) Charles Meiseln	nan			16. MOTHER'S NA	ME (First, Middle, Melden Le Wickne	Sumame)		
~ II	19a. INFORMANT'S NAME (Type/Print) Lewis Byer		2 4 1 0	Dexter	Avenue	Route Number City or Tow e, Silver	n, State, Zip Spr	code) ing	, Md. 209
20c. METHOD OF DISPOSITION 1 Burlal 2 Cremation 3 Ramoval from State 4 Donation 5 Other (Specify) 20c. LOCATION 20c. PLACE AND DATE OF DISPOSITION (Name of Christian Specific Processing Control of									rch, Va.
	21. SIGNATURE OF FUNERAL SERVICE LICE	NSEE .		22: NAME A	ND ADDRESS OF FA	Yh Funera	1 U o	m 0 0	
1	Moa D. a)elliam=	5			ch, Va. 2			
	23. PART i. Enter the diseases, or co ahock, or heart failure. LI	mplications that caused at only one cause on ea	the death. Do	not enter the mo	ode of dying, suc	ch se cardiac or resp	ratory arr	es1,	Approximate Interval Between
	IMMEDIATE CAUSE (Final disease or condition resulting in death)	. ^	enoin	atons	Land	enl_			Onset and Death
İ	e.	DUE TO JOR AS A	CONSEQUENCE O	7	0 -	t friler	,0		
5	Sequentially list conditions, b.	DUE TO (OR AS A	cons	sun	pear	of men			
	if any, leading to immediate ceuse. Enter UNDERLYING	ove to jon as a	A A	1010		0			
	CAUSE (Disease or Injury that initiated events	DUE TO (OR AS A	CONSEQUENCE O	F):					· · · · · · · · ·
CERTIFICATION	reaulting in desth) LAST								
	PART II. Other significant conditions	contributing to deeth bu	it not resulting	In the underlyin	g ceuse givyn in	Part I. 24s. WAS AN PERFO		24b.	WERE AUTOPSY FINDING
	Coronary	arlens o	Usen	1 Al	ex.	1 TYES	-	7	AVAILABLE PROPERTY OF CAUSE OF U.S. I.S. I.S. I.S. I.S. I.S. I.S. I.S.
FILTSICIAN: MEDICAL	10	eventy,	och	nyhali	7			1.5	YES 2 NO
	DID TOBACCO USE CONTRI	BUTE TO CAUSE OF	DEATH Y	ES 🗌 NO 🛭	UNCERTAI	N 🗆		1	
5	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	8. PLACE OF DEA	OTHER:					
2		1 Inpatient 2 ER/Outpa	itlant 3 🗆 DOA		ne 5 🗆 Rasidence	6 Other (Specify)			
	27. MANNER OF DEATH 1. Natural 5 Pending Investigation	26a. DATE OF INJURY (Month, Day, Year)	26b. TIN	JURY	JURY AT DRK? YES 2 NO	28d. DESCRIBE HOW	NJURY OCC	URED	
ובט פו	Accident Suicide 6 Could not be datarmined	26e. PLACE OF INJURY - building, etc. (Specific	At home, firm,	street, factory, offic	7m	261. LOCATION (Stroot City or Town, State)	and Number	or Rural R	Poute Number,
4	29a. CERTIFIER 1 CERTIFYING PHYSICI	AN: To the hart of my knowle	dna dauth ass	and at the steer 4 c	and alone and d	to the court of the court			
IM.	anal	AN: To the best of my knowle On the basis of examination							and manner as stated
COMPLEIED	295. SIGNATURE AND TITLE OF CHITTPEN	$ \mathcal{A}$, at the opinion,					
H I	4 Chot X	I redo	ten	mo	D 0 3 5 1 8	B B		2-13	- 95
2	30 NAME AND ADDRESS OF PERSON WHO	COMPLETED ONLOS OF DE	THE STREET OF STREET						

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Elliot R. Goldstein, M.D. 9410 Old Georgetown Rd., Bethesda, Md. 32. REGISTRAR'S SIGNATURE

DEC 1 8 1995

2081

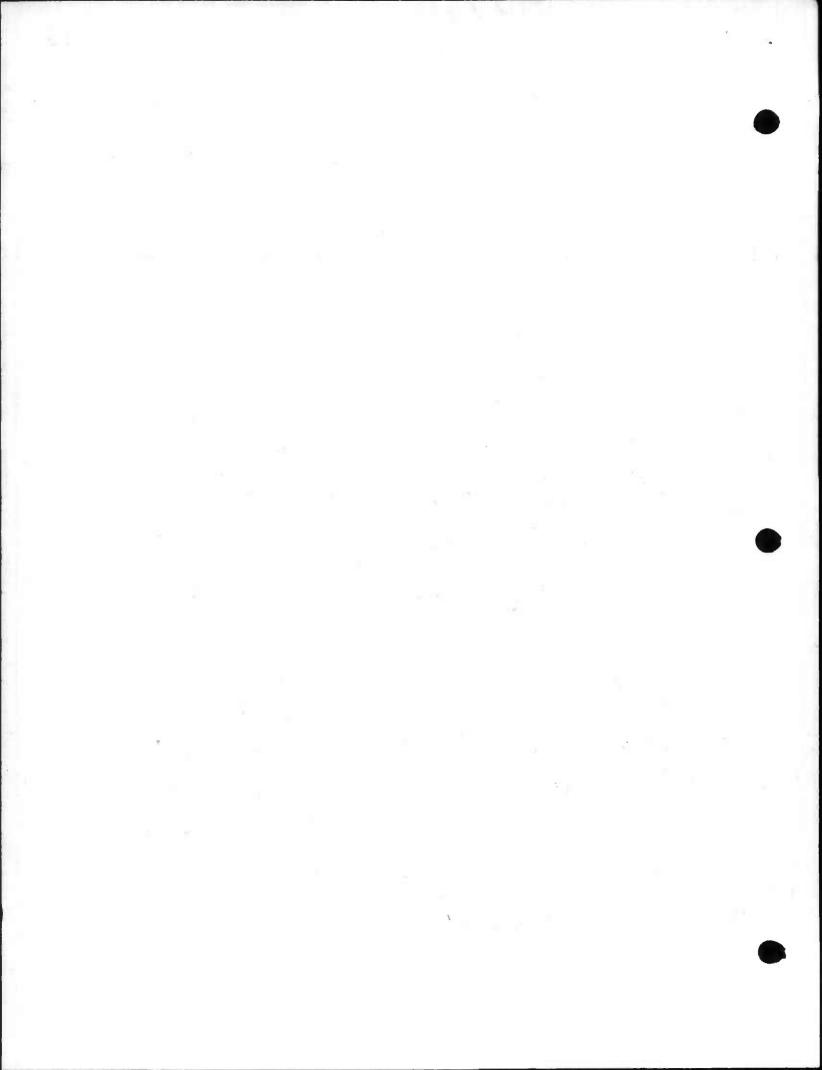


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	L. DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use	2 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	f Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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Pages 1, 2, 3.should

	1 - STATE STATE OF MARYLAND	/ DEPAR					MENTAL HYGIEN			
	1. DECEDENT'S NAME (First, Middle, Last) Samuel Balsam						2. DATE OF DEATH DOWNTH DECEMber		3. TIME OF DEATH 9:17 A.M	
	4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (in yrs. 1 ≥ M 2 □ F 86		IF UNDER	1 YEAR DAYS	IF UNDER	24 HRS. MIN.	7. DATE OF BIRTH	2,1909 N	IPLACE (State or Foreign	
OR	9a. FACILITY NAME (if not institution, give street and number) Hebrew Home			kvi.	R LOCATIO	ON OF DE	ATH	9c. COUNTY OF DEATH Montgomery		
DIRECTOR	10a. STATE 10b. COUNTY Maryland Montgomery		y, rown c kvil		ION				10d. INSIDE CITY LIMITS?	
FUNERAL	100. STREET AND NUMBER 6121 Montrose Road	1100	101. ZIP CODE 20852					10g. CITIZEN OF		
COMPLETED BY FUN	11. MARITAL STATUS 1 Never Married 2 Married 3 Wildowed 4 Divorced 12. WAS DECEDENT EVER IN U.S. FORCES? 1 YES 2 IF YES, GIVE WAR OR DATES	ARMED NO	13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yea or No — 14. RACE — Am If yea, specify Cuban, Maxican, Puerto Rican, etc.)						E — American Indian, k, White, etc.	
	(Specify only highest grade completed)	(Give kind of work done during most of working					JSINESS/INDUSTRY			
BE COM	17. FATHER'S NAME (First, Middle, Last) Joseph Balsam	1115F	ecu)T			ME (First, Middle, Maiden			
TO B	Susan Cantor		Mary Stein LING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zlp Code) 2 Lovejoy St. Silver Spring, MD 20902							
		EANDDATED	Tore	Cen	eter	y De	c. 12/15/9	CATION — City or TO 95 Suffo]	k, NY	
	Dya & Tellach		14/	2 N.	Was	hing	ton St.Fal	lls Churc	un'l Homes	
	23. PART I. Enter the diseases, or complications that caused the shock or heart feliure. List only one cause on each il iMMEDIATE CAUSE (Final disease or condition resulting in death) DUE TO (OR AS A CONSTITUTE OF THE CAUSE)	5/5							Approximata interval Between Onset and Death	
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): LSCHEMIC ULCER OF LEFT FOOT / WORTH, DUE TO (OR AS A CONSEQUENCE OF): ATHERO SLERDTIC PERIPHERAL ARTERIAL DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):									
7	TSCHEMIC CAR DIOMYOPATHY PERFORMED? JUYES 2 THO OF DEATH?								WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH? 1 YES 2 NO	
PHYSICIAN: MEDICA	EXAMINER? HOSPITAL:	ACE OF DEAT	S I I	only one)	UNC	ERTAIN	NQ			
	1 VES 2 NO 1 Inpatient 2 ER/Outpatient 27. MANNER OF DEATH 1 Natural 5 Pending (Month, Day, Year) 1 Accident	26b. TIME	4 DXNun	28c. INJU WO	JRY AT		8 Other (Specify) 28d. DESCRIBE NOW II	NJURY OCCURED		
TED BY	2 Accident Investigation 3 Suicide 6 Could not be determined 286. PLACE OF INJURY — At building, etc. (Specify)	home, farm, a	treat, fact	ory, office			281. LOCATION (Street a City or Town, State)	and Number or Rural I	Route Number,	
COMPLETED	29s. CERTIFIER (Check only one) 1 CERTIFYING PNYSICIAN: To the best of my knowledge, one) 2 MEDICAL EXAMINER: On the bests of examination and/o) and menner as stated.	
BE	296. SIGNATURE AND TITLE OF CERTIFIER Attending Ph	ysicia	n		29c. LICE	NSE NUM	BER	DEC.	(Month, Day, Year) 14,1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Typs, Print) D. PATEL M. D. G/2 p. MONTROSE R.D. ROCKV(LLE, M.D. 208. 31. DATE FILE (Majin, 1909) A BENEZIANT SANCARTURE								338		



permit. Pages 1, 2, 3 should BE COMPLETED BY FUNERAL DIRECTOR hours after death. Page 6 may be retained by the hospital or and TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within—4 hours after death. Page 6 may be retained by the hospital and TO THE FUNERAL DIRECTOR; After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached flire be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. 2 BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION 2

27. MANNER OF DEATH

1 Netural
2 Accident

3 Suicide

BALTIMORE, MARYLAND 212

DIVISION OF VITAL RECORDS, P.O. BOX 68760

				95 38116				
1 - STATE OF MAR		MENT OF HEALTH AND I	MENTAL HYGIENE REG. NO.					
1. DECEDENT'S NAME (First, Middle, Last) FLORENCE BROOKS 4. SOCIAL SECURITY NUMBER 5. SEX 6.	AGE (In yrs. lest birthday)	IF UNDER 1 YEAR IF UNDER 24 HRS.	2. DATE OF DEATH MONTH 12 14 7. DATE OF BIRTH	95 S. BIRTHPLACE (State or Foreign				
578-12-1208 1 🗆 M 2 🖳 F		IONTHS DAYS HOURS MIN.	November 13, 190	Country)				
9a. FACILITY NAME (If not institution, give street and number) University of Maryland Shock Tram		Baltimore	ATH 9c. (N/A				
10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSI Maryland Howard Columbia 1 □ yet								
100. STREET AND NUMBER 5651 Open Sky 101. ZIP CODE 102. CITIZEN OF WHAT COUNTRY? U.S.A.								
11. MARITAL STATUS 1 Never Merried 2 Married 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 XNO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuben, Maxican, Puerto Ricen, etc.) 14. RACE — American Indian Black, White, etc. 15. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuben, Maxican, Puerto Ricen, etc.) 16. PER 2 X NO Specify: Black								
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 10 16b. KIND OF BUSINESS/INDUSTRY (Give kind of work done during most of working life. Do NOT use retired.) Nurse L.P.N. Health Field								
17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname)								
William J. Chisley Carrie T. Gaunt								
190. INFORMANT'S NAME (Type/Print) Sylvia A. Cofield		Open Sky Columbia,		s, Zip Code)				
20a. METHOD OF DISPOSITION 1X Burlal 2 Cremation 3 Removal from State 4 Donetion 5 Other (Special)	206. PLACE AND DATE OF PARTY LAND NATIONAL PROPERTY LAND NATIONAL PR	onal Cemetery Dec.		N — City or Town, State 1, Maryland				
21. SIGNATURE OF PUMERAD SERVICE LICENSEE	to f	Leroy M. & Russel 1630 Edmondson Av	ll C. Witzke Fund Tenue Catonsville	e, Maryland 21228				
23. PART I. Enter the diseases, or complications that considered shock, or heart fallure. Liet only one cause IMMEDIATE CAUSE (Final	on each line.			interval Between Onset and Daath				
disease or condition resulting in death) e. SEVE DUE TO (OR	E HEAD AS A CONSEQUENCE OF):	IN YXVEN	rh Complications	2 WEEKS				
t any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury	AS A CONSEQUENCE OF):	CONTROL OF	ION APPROVED BY MEDICAL	EXAMINER				
reaulting in deeth) LAST	that initiated eventa Due 10 (or as a consequence of):							
PART II. Other algnificent conditions contributing to dea	eth but not resulting in	the underlying ceuse given in	Part i. 24s. WAS AN AUTOF PERFORMED?	AMAILABLE PRIOR TO				
Dementia				1 - YES 2 NO				
DID TOBACCO USE CONTRIBUTE TO CAUS			N 🗆					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL:	26. PLACE OF DEATH	(Check only one) OTHER:						

Month, Day, Year)

26c. INJURY AT WORK?

fell down steps Opensky

29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my kno to the cause(s) end manner ea stated.

29c. LICENSE NUMBER

247776

Day.

PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

CARLO J.GAMMAITONI Attention Cordal 31. DATE FILED (Month, Day, Year)
LEC 1 8 1995

22.S.GREENE ST.BALTIMORE, MD #21201

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely	be filed within 72 hours after death with the State Dept. of Health and Mental Hyghene prior to burial, crems IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event,
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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF OEATH 3. TIME OF DEATN JOHN GEORGE BEYER DECEMBER 1995 15 9:25 A. 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs, lest birthday) IF UNDER 1 YEAR 7. DATE OF BIRTN IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign MARCH 17,1906 217-03-9428 1 X M 2 - F 89 YRS. MARYLAND 9a. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATN 9c. COUNTY OF DEATH IRVINGTON KNOLLS CARE CENTER DIRECTOR BALTIMORE BALTIMORE CITY RESIDENCE OF DECEDENT 10a. STATE 10b. COUNT 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? MARYLAND BALTIMORE CITY BALTIMORE 1 X YES 2 NO permit. FUNERAL 10a, STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 419 S. SMALLWOOD STREET and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit burial, cremation, or removal. 21223 U.S.A. retained by the hospital or attending physician. 12. WAS OECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-If yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. MARITAL STATUS 14. RACE - American Indian, Black, White, etc. BALTIMORE, MARYLAND 21215-0020 1 X Never Married 2 Married 1 TYES 2 NO Specify BY 3 Widowed 4 Divorced Specify: WHITE 15. DECEDENT'S EDUCATION COMPLETED 16e. DECEOENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b, KIND OF BUSINESS/INDUSTRY (Specify only highest grade comp Elementary/Secondary (0-12) College (1-4 or 5+) 6TH GRADE GENERAL MAINTENANCE BOWLING LANES 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First Middle Maiden Surname) to GEORGE BEYER KATHERINE MABUS BE notified 19a. INFORMANT'S NAME (Type/Print 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 AUGUSTA KESTLER 448 FURROW STREET - BALTIMORE, MD 21223 Page 6 may be 9 20. METHOD OF DISPOSITION
1 \(\Delta \) Burlel 2 \(\Bullet \) Cremation 3 \(\Bullet \) Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State must WESTERN CEMETERY 4 Donation 5 Other (Specify) BALTIMORE examiner 21 SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY hours after death. HUBBARD FUNERAL HOME, INC. a 4107 WILKENS AVENUE-BALTIMORE, MD medicai 23. PART V Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximats shock, or haert fallure. List only one cause on each line interval Betwe IMMEDIATE CAUSE (Final Onset and Death the disease or condition_ 0 or other traumatic event, resulting in death) DUE TO (OR AS A CONSEQUENCE CERTIFICATION Sequentielly list conditions, the attending physician a Mental Hygiene prior to if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury OUE TO (OR AS A CONSEQUENCE that initiated events resulting in death) LAST PART II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY 24b, WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE MEDICAL and t shows any signed ! 1 YES 2 NO OF DEATH? 1 YES 2 NO been of I DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES INO UNCERTAIN PHYSICIAN: Dept. 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATN (Check or Item certificate the State HOSPITAL 1 YES 2 NO. 1 Inpatient 2 ER/Outpatient 3 DOA Nome 5 Residence 6 Other (Specify) 0 22. MANNESS OF DEATH 28a. DATE OF INJURY (Month, Day, Year) marked, 28b. TIME 28c. INJURY AT WORK? 28d. DESCRIBE NOW INJURY OCCURED this (INJURY 1 Netural 84 1 YES 2 NO After 1 death BY 28a. PLACE OF INJURY — At home, farm, atreet, factory, office building, atc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) .00 3 Suicide 8 Could not be COMPLETED DIRECTOR: hours after 28 4 Nomicide

RTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

su au

MARCELINO ALBUERNE - 516 N. ROLLING ROAD - SUITE 204 - CATONSVILLE, MD 21229

COMPLETED CAUSE OF DEATH (ITEM 27 Type, Print)

32. REGISTRAR'S SIGNATURE

Tili Develor Randal

ation and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(s) and manner as stated.

29d. DATE SIGNED (Month, Day, Year)

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DHMH-16 Rev 1/89

29c. LICENSE NUMBER

BE

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31. DATE FILED (Month, Day,

1995

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FOR STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REGISTRAR 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH RAYMOND BRINZER 12 -1995 5=40 PM 6. AGE (In yrs. last birthday) 4. SOCIAL SECURITY NUMBER 5. SEX IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year) 8. BIRTHPLACE (State or Foreign Country) DAYS HOURS 1 XM 2 - F 76 162 14 0681 VDS 1919 Pennsylvania Aug. 15, Ba. FACILITY NAME (If not institution, give street and number) 95 CITY TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH Maryland General Hospital Baltimore City DIRECTOR Baltimore City RESIDENCE OF DECEDENT 10a STATE 10h COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Anne Arundel Riviera Beach 1 YES 2 NO 10a, STREET AND NUMBER FUNERAL 101, ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? 256 Carvel Road 21122 U.S.A. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 X YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, White, etc. 1 Never Married 2 X Married If yes, specify Cuban, Mexican, Puarto Rican, atc.) 1 YES 2 X NO Specify Specify: BY 3 Widowed 4 Divorced World War II White COMPLETED 16e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade comple Elamentary/Secondary (0-12) College (1-4 or 5+) Plant Supervisor 12th Steel Industry 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Michael Brinzer Elizabeth Gardener BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Genevieve Brinzer 256 Carvel Road Riviera Beach, Maryland 21122 20s. METHOD OF DISPOSITION

1 Startel 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State DATE Cedar Hill Cemetery 12/15 Baltimore, Maryland 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY George J. Gonce Funeral Home P.A. Race 4001 Ritchie Hwy. Baltimore, Md 21225 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart fellure. List only one cause on each line IMMEDIATE CAUSE (Final disease or condition Carcinomatosis 3 years reaulting in death) DUE TO (OR AS A CONSEQUENCE OF): Prostatic Carcinona 3 years CERTIFICATION Sequentielly list conditions. DUE TO (OR AS A CONSEQUENCE OF) if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (DR AS A CONSEQUENCE DF): that initieted eventa resulting in death) LAST PART II. Other significent conditions contributing to deeth but not resulting in the underlying ceuss given in Part i. 24a, WAS AN AUTOPSY 24h. WERE AUTOPSY FINDINGS MEDICAL AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 TES ZYNO 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) **EXAMINER?** HOSPITAL: OTHER: 1 TES 2 NO 4 Nursing Home 5 Residence 8 Other (Specify) 28a. DATE OF INJURY (Month, Day, Year) 27. MANNER OF DEATH 28b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1X Natural 5 Pending Investigation 1 YES 2 NO BΥ Accident 28e. PLACE OF INJURY — At home, farm, street, fectory, offica building, etc. (Specify) 281, LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 8 Could not be COMPLETED 4 Homicide 29a. CERTIFIER
(Check only one)

One)

MEDICAL EXAMINES: On the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, end due to the ceuse(a) and manner as stated. 29b. SIGNATURE AND STITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE anulprasa December 12,1995 89260 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Ganesh Prasad, M.D. c/o Maryland Ceneral HOspital

32 REGISTRAT'S SONATORES

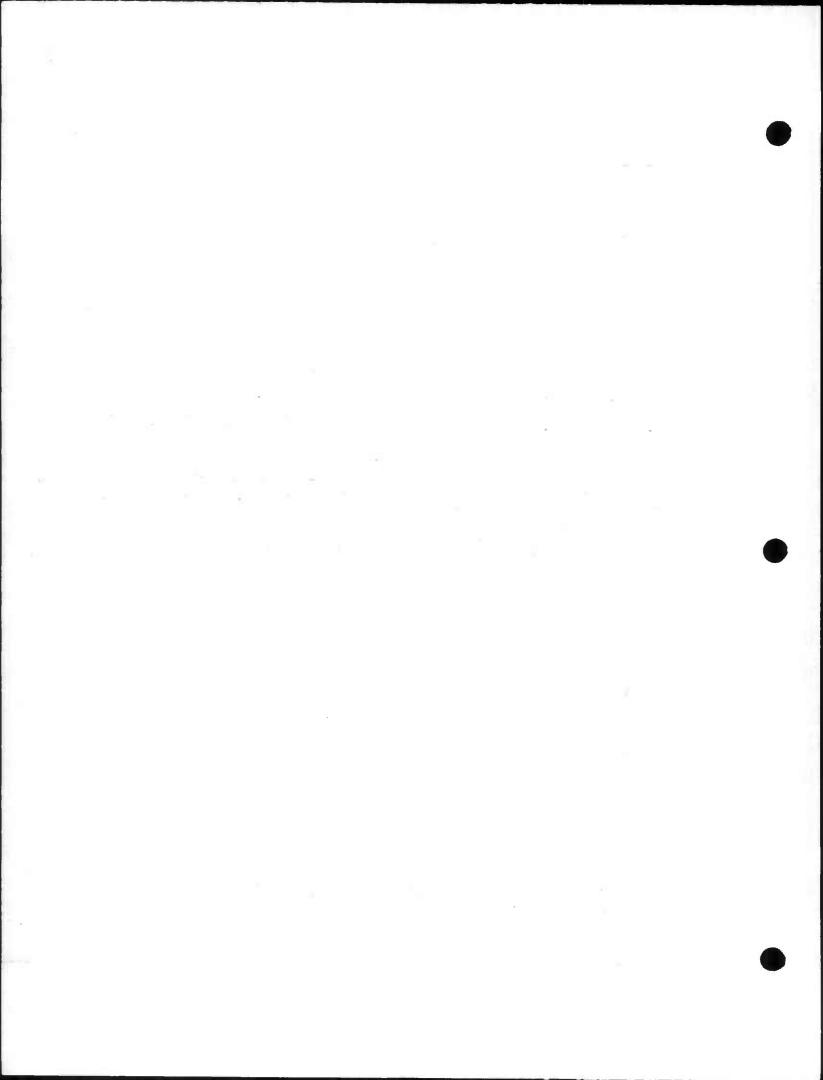
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

1	FOR STATE REGISTRAR
	1. DECEDENT'S NA
L	DONALD
ı	4. SOCIAL SECURI

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

	1. DECEDENT'S NAME (First, Middle, Last)						2. DAT	TE OF DEATH	av v	EAR 3.	TIME OF DEATH
- 1	DONALD Lee BISC		CEMBER	11.199		4:26 P M					
	4. SOCIAL SECURITY NUMBER		AGE (In yrs. lest birthde	"	NDER 1 YEAR	IF UNDER 24 HRS.	7. DAT	E OF BIRTH	6.	BIRTHPL	ACE (State or Foreign
	218-26-0419	1 X M 2 🗆 F	65 YRS	B. MONT	HS DAYS	HOURS MIN.	Api	ril 22,	1930	Mary	land
	9e. FACILITY NAME (If not institution, give str	reet and number)		9b.	CITY, TOWN	OR LOCATION OF			9c. COUNTY	OF DEAT	Н
OR	THE JOHNS HOPKINS	HOSPITAL.		B/	ALTIMO	ORE CITY				N/A	
5	RESIDENCE OF DECEDENT 10e, STATE 10b, COUNTY		1400		WN OR LOCA					1.0	d, INSIDE CITY
DIRECTOR	Maryland Baltimore Do							undalk			LIMITS?
Z	106. STREET AND NUMBER 7845 Kentley Road 107. ZIP CODE 21222 109. CITIZEN OF WHAT CO										
FUNERAL											
5	11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMEO 13. WAS DECENDENT OF H 1 Never Married 2 [X] Married 12. WAS DECENDENT OF H 17. WAS DECENDENT OF H 18. WAS DECENDENT OF H 19. W								or No-	Black, V	American Indian, fhita, etc.
BY	3 Widowed 4 Divorced	IF YES, GIVE WAR	OR DATES		1 TYE	TES 2 NO Specify: Specify:				White	
0	15. DECEDENT'S EDUC	CATION	16a. DECEDEN	T'S USU/	AL OCCUPAT	ION	T 1	6b. KINO OF BU	SINESS/INOUS	TRY	WILLE
	(Specify only highest grade of Elementary/Secondary (0-12)	College (1-4 or 5+)	(Give kind life. Do NO	of work of Tuse retir	fone during m red.)	ost of working					
7	12 Years	conege (1-4 of 3-4)	Fo	remo	an.			Constru	iction	Indi	istry
COMPLET	17. FATHER'S NAME (First, Middle, Last)					18. MOTHER'S N	_	t, Middle, Malden			
	Conrad J. Bischo	66				Ella	M. L	loud			
BE (19a. INFORMANT'S NAME (Type/Print)	-				and Number or Rura	Il Route Nu	amber, City or Tox			
2	Mrs. Ethelreda E.	· Bischoff	784	45 K	entle	y Road	Duna	lalk, Mi	arylan	d 2	1222
	20s. METHOD OF DISPOSITION 1/13 Burlel 2 Cremetion 3 Remo		20b. PLACE AND DA	TEOFDIS	SPOSITION (A	lame of	0	ATE 20c. LC	CATION - CIT	y or Town	, State
	4 Donation 5 Other (Specify)	IVEI from State	Sacrement of	HIT.	oco of J	esus Cem	112/1	5/95	Dundal	k, M	aryland
	21. SIGNATURE OF PUNICIPAL SERVICE LICE	DASEE /	//		22. NAME /	AND AODRESS OF	FILINO	ral Hor	ne of	Dund	alk, Inc.
	1 her h	test	1/		79	22 Wise	Ave.	Dund	alk, M	D 2	1222
	23. PART I. Enter the diseases, or c	omplications that ca	used the death. D	o not e	nter tha m	ode of dying, su	uch aa c	ardiac or reap	iratory arres	ıt,	Approximate
	ahock, or haart failure. I IMMEDIATE CAUSE (Final	1 .									Onset and Death
	disease or condition and the second strength of the second strength										
	DUE TO (OR AS A CONSEQUENCE OF):										
z											
CERTIFICATION	Sequentially list conditions, the my, leading to immediate DUE TO (OR AS A CONSEQUENCE OF):										
2	CAUSE (Disease or Injury	C									
	that initiated eventa resulting in death) LAST	DUE TO (OR	AS A CONSEQUENC	E OF):							
E I	Total and a second part of the s	J									
	PART II. Other algnificant condition	e contributing to dea	ath but not rasulti	ng In th	e underlyl	ng cause given	In Part I.				ERE AUTOPSY FINDINGS
EDICAL								PERFO		C	MILABLE PRIOR TO OMPLETION OF CAUSE
								1 1 123	XIII		F DEATH?
Ψ.	DID TOBACCO USE CONTR	RIBUTE TO CAUS	E OF DEATH	YES [T NO I	UNCERTA	IN D				
NA I	25. WAS CASE REFERRED TO MEDICAL		26. PLACE OF 1	DEATH (C							
PHYSICIAN:	EXAMINER? 1 YES 2 NO	HOSPITAL:	NOutpatient 3 🗆 OD	A 4	HER: Numina Ho	ma 5 🗆 Residenc	a 8 🗆 O	ther (Specify)			
H	27. MANNER OF DEATH	28s. OATE OF INJ	URY 28b.	TIME OF	28c. If	JURY AT		DESCRIBE HOW	INJURY OCCU	RED	
	1 Natural 5 Pending Investigation	(Month, Oay,)	rear)	INJURY		YES 2 NO					
) BY	2 Accident 3 Suicide 8 Could not be	28e. PLACE OF IN building, atc.	JURY — At home, le	rm, street	, tectory, off	Ica		OCATION (Street		Rural Rou	te Number,
COMPLETED	4 Homicide determined	buttoning, sic.	(Specify)					ifty or Town, State)		
۳	29a. CERTIFIER 1 X CERTIFYING PHYSIC	CIAN: To the best of my	knowledge, death oc	curred at	the time de	to and place and d	lue to the	cause(s) and ma	nner es eleter		
ME I	CONSCRIPTION OF THE PROPERTY O	R: On the basis of axami									nd manner as stated.
	200. SANTORE AND TIME OF TERTIFIER			1		29c. LICENSE N					Fonth, Day, Year)
띪	MILANIAIV/V/	1.001411	1 1/1	1		140	INCS /	/	DATE:	SIGNED IM	onth, Day, Tear)
2	30. NAME AND ADDRESS, OF PERSON WHO	O COMPLETED CAUSE (OF DEATH (ITEM 27)	Type Print	1)	11/1/	171		vec	CALLIC	11, 1773
	11.1.1.1.1.9.11.	111	and 11 (1)	11	Strain	+ Man	× 9-	140 K	altine	Aco	11776
	31. DATE FILEO (Month, Day, Year)	32. REGISTRANS	SIGNATURE	46	01/66	- Total	0	0	alling	110	~1/1
	DEC 1 8 1995 ,	المعالمة المالية	MOUNT								
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BALTIMORE, MARYLAND 21215-0020

TO BE COMPLETED BY FUNERAL DIRECTOR

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed witum 24 hours after death. Page 6 may be retained by the hospital or attending physical	TO THE FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burning a state of the companies. The burning of the companies	IMPORTANT: If item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.
4E HOSPITAL OR ATTENDING P	de FUNERAL DIRECTOR: After to	DRTANT: If item 28 is man
101	TOT	M

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

								35	
1 - STATE REGISTRAR	STATE OF MA				F HEALTH AND	MENTAL HYG	IENE		
1. DECEDENT'S NAME (First, Middle, Lest)				OAIL C	DEATH	2. DATE OF DEAT			. TIME OF DEATH
DOROTHY	AGN.		Œ	LE		MONTH 12	- 13	YEAR 95	1137 Am
4. SOCIAL SECURITY NUMBER 212-16-3108	5. SEX 8	74		MONTHS DA		7. DATE OF BIRTH (Month, Dey, Ye) JUNE 24	nr)	Country)	ACE (State or Foreign
9a. FACILITY NAME (If not institution, give s BON SECOURS HOSE				9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY O			INTY OF DEA	ATH	
RESIDENCE OF DECEDENT						L	DAL	1 I IMUK	E CITY
MARYLAND BAI	r TIMORE CI	ΓY	10c. CITY,	TOWN OR LO	LTIMORE			- 1	Od. INSIDE CITY LIMITS? YES 2 NO
100. STREET AND NUMBER 317 SOUTH MONROE	CTDEET				10f. ZIP CODE 2122)	200		AT COUNTRY?
11. MARITAL STATUS	12. WAS DECEDENT	VER IN U.S. AF	RMED		DECENDENT OF HISPA	NIC ORIGIN? (Specif	ly Yea or No-		- American Indian, White, etc.
1 Never Married 2 X Married 3 Widowed 4 Divorced	FORCES? 1 [OR DATES	NO		s, specify Cuban, Mexic YES 2 X NO Speci		2.)	Specify:	
15. DECEDENT'S EDU (Specify only highest grade	completed)	(0		ork done during	PATION g most of working	16b. KIND O	F BUSINESS/IN	DUSTRY	
Elementary/Secondary (0-12) 6TH GRADE	College (1-4 or 5+)			EMAKER			DOME	ESTIC	
17. FATHER'S NAME (First, Middle, Last) CHARLES SANDERS					18. MOTHER'S NA EMMA	AME (First, Middle, M. HAUG	alden Surname)		7
19a. INFORMANT'S NAME (Type/Print) ROBERTA WELCK		19			GALE AVEN		r Town, Statu, Zi		21229
20a METHOD OF DISPOSITION 1 ABurial 2 Cremation 3 Ren	oval from State	cemetery, cri	PLACE AND DATE OF DISPOSITION (Name of etery, crematory or other place)			DATE 20c. LOCATION — City or Town, Stat			
4 Donation 5 Other (Specify) GLEN HAVEN CEMETERY 12/16 GLEN BURNIE, MI							MD		
of sure		lus			ARD FUNERA WILKENS			E MD	21229
23. PARLL prer the diseeses, or									41441
immediate cause (Final	a. A N X DUE TO (0	DN each line	OUENCE OF	ot enter the	mode of dying, aud				Approximate interval Between Onset and Death
immediate cause (Final	a. And And Due to (c) b. Clark Due to (c) c. Pulm	DN each line	M. C.C. SULENCE OF SOLENCE enter the	mode of dying, and				Approximate interval Between Onset and Death	
immediate cause feliume. Immediate cause (Final disease or condition reaulting in death) Sequentially list conditions, if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events	a. A N X DUE TO (C b. DUE/TO (C c. Pulm DUE TO (C) d.	R AS A CONSE	OUENCE OF	enter the	mode of dying, aud	ch aa cardiac or i		24b. V	Approximate interval Between Onset and Death Sou
hock, or heert fellure. IMMEDIATE CAUSE (Final disease or condition reaulting in death) Sequentielly list conditions, if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events reaulting in death) LAST	B. AND DUE TO (C) DUE TO (C) DUE TO (C) DUE TO (C) DUE TO (C)	R AS A CONSE	OUENCE OF	ot enter the	mode of dying, aud Lopally	h aa cardiac or in a cardiac o	reapiratory at the second seco	24b. V	Approximate interval Between Onset and Death S day
immediate cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significent conditions. DID TOBACCO USE CONT	B. AN X DUE TO (0 DUE TO (0 DUE TO (0 DUE TO (0 DUE TO (0 DUE TO (0 DUE TO (0 DUE TO (0 DUE TO (0 DUE TO (0	P AS A CONSE	CE OF DEATH	ot enter the	mode of dying, aud	n Part i. 24a. W	IS AN AUTOPSY RFORMED? ES 2 MO	24b. V	Approximate interval Between Onset and Death S day
immediate cause (Final disease or condition resulting in death) Sequentielly list conditions, if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significent conditions. DID TOBACCO USE CONT	BRIBUTE TO CAU	PR AS A CONSE	OUENCE OF	ot enter the	mode of dying, aud logally y lying cause given in UNCERTAL one) Home 5 Realdence	n Part i. 24a. W	AS AN AUTOPSY RFORMED? ES 2 M(NO	24b. V	Approximate interval Between Onset and Death Sou
hock, or heer feliure. iMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentielly list conditiona, if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significent condition to the condition of the condit	BUTE TO CAU RIBUTE TO CAU HOSPITAL: 1 Kinpstant: 28a. Date of In (Month, Day)	R AS A CONSE	CE OF DEATH 28b. TIME 100 ENCE OF)	ot enter the	tying cause given in UNCERTAL one) Home 5 Rasidence INJURY AT WORK? YES 2 NO	Part i. 24a, William Per i ye ye ye ye ye ye ye ye ye ye ye ye ye	IS AN AUTOPSY RFORMED? ES 2 MNO	24b. V	Approximate interval Between Onset and Death Sou
MMEDIATE CAUSE (Final disease or condition reaulting in death) Sequentielly list conditiona, if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events reaulting in death) LAST PART II. Other significent condition DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending	BRIBUTE TO CAU	De per each final and a conse of the conse o	CE OF DEATH 28b. TIME 100 ENCE OF)	ot enter the	tying cause given in UNCERTAL one) Home 5 Rasidence INJURY AT WORK? YES 2 NO	Part i. 24a. W	AS AN AUTOPSY RFORMED? ES 2 (MO I) HOW INJURY OF	24b. V	Approximate interval Between Onset and Death Sou
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TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detach		IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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filled	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	the n
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STATE OF	MARYLAND /	DEPARTMENT	OF HEALTI	AND	MENTAL	HYGIENE
	CI	ERTIFICATE	OF DEA	TH		REG. NO.

	FOR 1 - STATE REGISTRAR	STATE OF MARYLA	ND / DEPARTA			MENTAL	HYGIENE REG. NO.				
	1. DECEDENT'S NAME (First, Middle, Last) HELEN C	C/999				2. DATE O MONTH DE	C 14	95	2	7120 A	
		□ M 2 X F 48	YRS. MO	NTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	FEB.	Day, Your) 14,1947	Co	LTIN	ORE, MD	
STOR	ST. AGNES HOSPITAL				LTIMORE			BALTIMORE CITY			
DIRECTOR	MARYLAND 10b. COUNTY	BALTIMORE		y, town or location ATONSVILLE					1000	. INSIDE CITY LIMITS? YES 2 X NO	
FUNERAL	307 GLENRAE DRIVE		10f.	1	U.S.		COUNTRY?				
BY	11. MARITAL STATUS 1 Never Married 2 X Married 3 Widowed 4 Divorced	P. WAS DECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR DAT	2 XNO	if yes, spe	NDENT OF HISPAN city Cuban, Maxica 2 XNO Specify	n, Puerto Ri			Black, Whi specify:	American Indian, lita, atc.	
LETED	15. DECEDENT'S EDUCATI (Specify only highest grade con Elementary/Secondary (0-12)	16a. DECEDENT'S US (Give kind of work life, Do NOT use in	k done during mos etired.)	t of working	RAT	KINO OF BUSIN			ECTRIC		
BE COMPLET	17. FATHER'S NAME (First, Middle, Lest) HOWARD CHENOWETH	YR	COSTOPLER	KBI KES	16. MOTHER'S NAI NETA RU	ME (First, Mi					
TO B	19a. INFORMANT'S NAME (Type/Print) MR. JAMES E. CLAGG				IVE - CA				,		
	20s. METHOO OF DISPOSITION 1 Disposition 10 Dispositio										
	- Jakie D.	Shanno	~	4107 W	D FUNERA	VENU	E-BALTI	MORE.	MD	21229	
	23. PART/1 Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or reapiratory arrest, shock, or heert feliure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) a. Hepatocellular Carcinoma But TO (OR AS A CONSEQUENCE OF):										
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that Initiated events resulting in death) LAST b. OUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):										
MEDICAL C	PART II. Other aignificant conditions of	contributing to deeth bu	ut not reaulting in	the underlying	ceuse given in	Part i.	24a. WAS AN AL PERFORMI 1 YES 2	ED?	COI OF	RE AUTOPSY FINDINGS ILABLE PRIOR TO MPLETION OF CAUSE DEATH? YES 2 K NO	
PHYSICIAN: I	DID TOBACCO USE CONTRIE 25. WAS CASE REFERRED TO MEDICAL		F DEATH YES		UNCERTAIN	N					
YSIC	1 TYES 2 NO 1	OSPITAL: Inpetiant 2 ER/Outpe	itlant 3 DOA 4		5 Rasidenca						
	27, MANNER OF DEATH 1 Natural 5 Pending Investigation	28a. DATE OF INJURY (Month, Day, Year)	26b. TIME C	Y WO	PRY AT PRK? ES 2 NO	28d. DESC	CRIBE NOW INJ	URY OCCURE	D		
TED BY	2 \(\) Accident investigation 3 \(\) Suicide 6 \(\) Could not be detarmined	28e. PLACE OF INJURY building, etc. (Speci	At home, farm, stre	et, factory, office			TION (Street and r Yown, State)	Number or Re	iral Floute	Number,	
COMPLET	29a. CERTIFIER (Check only one) 1 CERTIFYING PNYSICIAL EXAMINER: (N: To the best of my knowle							180(S) BN	d manner es stated,	
H	29b, SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER D 4 7 5 9 5 29d. DATE SIGNED (Month, Day, Year)				195 Day, Year)					
10	30. NAME AND A ODRESS OF PERSON WHO C	ing Roa	ATH (ITEM 27) (Type, Pr BUI	Hiun	e, MD	21	228	'-J.	Hue	efner H	
	DEC 1 & 1005 Julia	32. REGISTRAND SIGNA	No.								



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ITEMS: 23 PART I, 27, PER State of Maryland / Department of Health and Mental Hygiene 95

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		HEU	FILM 6-/31 1/4/90 t	. τ		Certificat	e or	Deat	n		Reg. No.			
			1. Decedent's Name (First, Middla, L	ast)						2. Data of De		.000	3. Time of Dea	ath
	Physic		JOHN +	lenru			CO	XON	JR	DEC.	11	1995	23:27	P
i,	/Medi Exami		4a. Facility Neme (If not institution, gi							ocation of Deat	1	ounty of Deetl		-
تن	LAGIIII	ici			посртт	λľ		BALT	IMOF	F		/A		
	Funeral		JOHN HOPKINS 5. Sociel Security Number 6.	Sex 7. Ag	e (In yrs. lest birt		1 Yaar		er 24 Hrs.				nnlece (State or Fo	raior
	Funeral Director		217~34~5045 Usuel Residence of Decedent	MIN ADE		rs. Months	Deys			8. Data of Bir (Month, Da April	3,193	7 Ma	hplece (Steta or Fo untry) Lyland	algi
	show	_	10e. Stata 10b. County		10c. City, Town								10d. Inside City Li	
	M Page	Director	Maryland Bo	ltimore			idal	.k						ONL
	23a or 2	al Dir	8024 Bank Street	L		10f. Zip	Code	212	224			ed Sta		
Baltimore, Maryland 21215-0020 permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hygiene. Important: if hem 27 is marked other than "natural", or items 23s or 28s-f show shiply or other traumatic event, the Medical Engines must be notified at once.	by Funeral	11. Meritel Stetus 1 □ Nevar Married 2 □ Married 3 □ Widowed 4 □ Divorced	12. Wes Decedent I Armed Forces? 1 Yes 2 N If Yes, Give Yeer or Detes:	Ever in U,S. No	13. Wes Deced				ecify Yas or No Rican, etc.)		Rece - Amai Bleck, White pecify:			
ŏ	2 hou		15. Decedent's E	ducation	16a.	Decedent's Usua	el Occu	petion			16b. Kind	of Business/I	Industry	_
215	7 uic Man	Completed	(Specify only highast gi	rade completed)		(Give kind of wo	rk done se retire	during mo	ost of work	ing			,	
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B	Hyy office	0	17. Fether's Neme (First, Middle, Las	t)		owje O conz	10/4	18. Mot	har's Name	e (First, Middle			usney	
10	fents fents fents fents	To Be	John Henry Coxon	1. Sr.				He	len B	ittner				
ary	Should No Market		19a, Informent's Neme/Reletionship		19b.	Meiling Address	(Stree				er, City or T	own, State, Z	(ip Code)	
Ž	nd 2 aith a 27 le		Mrs. Rita M. Co.	con	8	024 Bank	2 St	reet	Bal	timore.	MD	21224		
re,	othe othe		20e. Method of Disposition		20b. Plece of	Disposition (Nen	ne of			Dete		tion - City or	Town, Stata	
D E	Pages nent of } ant: if he ury or of		V Buriai 2 □ Cremation 3 I 4 □ Donetion 5 □ Other (Spec		1			•	10	111/05	Deres	dallh	ND.	
	nit. F		21. Signature of Fune of Service Lice		Sacrea	Ht. Of 22. Nama an	d Addr	ase of Fac	ility					_
Ba	Department of the population o		101			Dudo	i-Ru	ick Fi	unera	l Home	of Du	ndalk,	Inc.	
			1970	1_		7922	2 Wi	se A	ve.	Dundalk	, MD	21222		
			282 Part1. Enter the disease, or con shock, or heart feilure. List only	one ceuse on each lin	the deeth. Do n ne.	ot enter the mod	e of dy	ing, such a	is cardlec	or raspiretory a	rrest,		Approximata Interval Between Onset and Deat	
	Physician // // // // // // // // // // // // //		Immediate Course (Final									I	Onset and Deat	л
	Examiner		Immediate Cause (Finet disease or condition resulting in death)	0	ATHEROSCLE	ROTIC CAR	DIOV	ASCULA	R DISE	ASE				
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	certificate be executed iding physician and ise as the burial-transit	хал	Sequentially list conditions, if any leading to immediate		Due to (or es a c	onsequence of):								
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ox 68760,	ohysi the	/Medical	that initieted events resulting in death) Lest		Dua to (or es e co	onsequence of):						1		
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Bo	- 5 -	lan	, T	U										
	0 0 0	Physician	Pert II. Other eignificant conditions	contributing to death bu	it not resulting In	tha underlying c	ause gi	iven in Per	t I.	23b. Did	tobacco ue	e contribute	to the cause of de	eth?
<u>о</u>	d by detac									10	Yee 2	No 3□Pr	obably 42 Unk	now
Division of Vital Records,	requires that the seen signed by the	þ										T		
0	been s	Completed									en eutopsy med?		Nere autopsy finding available prior to completion of cause	
ec	> 11 61	pje								1			of death?	,
	Pa ate	8								181	Yes 2□i	No i	Yes 2 No	
<u>ta</u>	Physician: The this certificate and director, par	Be (25. Was cese referred to medical exeminer?					26. Pla	ce of Deet	h (Check only	one)			
-	5 00	ဥ	1 TYPes 2 □ No	Hospitel: 1 ☐ Inpatie	nt 25 ER/Out	patient 3 DC	A Ot	har: 4□ N	Nursing Ho	me 5□Resi	dence 6 D	Other (Spec	city)	
0	ding Ph h. After th funeral	ü	27. Menner of Death 1XX Neturel Sending	28e. Dete of Injur (Month, Dey	y 28b. Ti	me of 2	8c. Inju Wo	iry et ork?		28d. Describe	how Injury o	ccurred		
0	Attending or deeth.	ati	2 ☐ Accidant Invastigetic	on		М		Yes 2	□No					
Š	or Attendation after deet Director:	ertification:	3 ☐ Suicide 6 ☐ Could not to determined	28e. Plece of Inju	ry - At home, fen	m, street, fectory	, office			28f. Location (: City or To		lumber or Ru	ral Route Number,	
	tal or al Dir led in	O			,-,,						,			
	To the Hospital or Attending Ph within Ed hours after deeth. To the Funeral Director: After th completely filled in by the funeral	edical	29a. Certifier 1 Certifying Pl (Check only one)	nysician: To the best of miner: On the basis of and menner sta	exemination and	deeth occurred of for Investigetion,	et the ti	lme, dete e oplnion, de	and place, and place,	and dua to the red et the time,	ceuse(s) en dete end pi	d manner es ece, end due	stated. to the cause(s)	
	To the within 2 To the comple	Me	29b. Signature and title of certifiar	1/		290	. Licen	sa number	r		29d. Data a	igned (Month	n, Day, Year)	
	. ,,,		1011-	w Uhill	/	0	.C	M.E.			DECE	MBER	12, 199	15
	19	ŀ	30. Name and address of person who	completed cause of de	eth (Item 23e) (
	1		M a A A A A A A	Tampioto oadao of de	(on 20a) (, po, . (m)						4 .	2 21201	

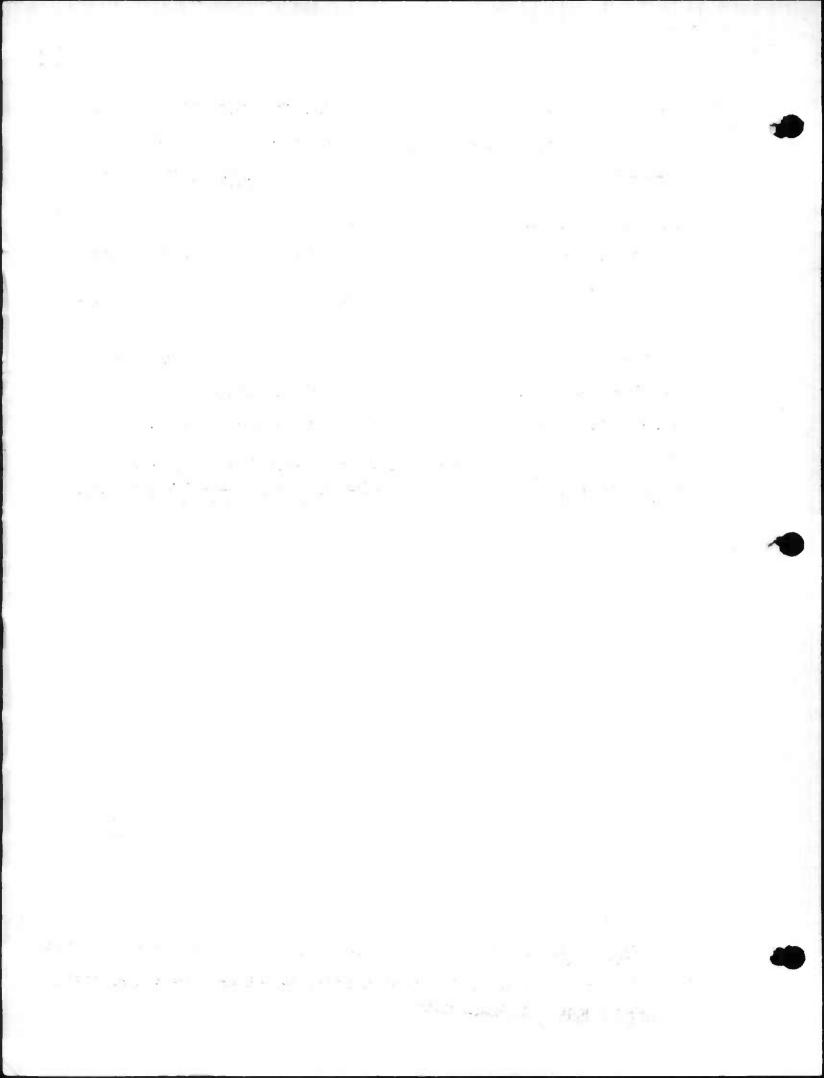
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MANUS A COLECUM 111 Penn Street, Baltimore, Maryland 21201
31. Dete filed (Month, Del, Year)

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	1 - FOR STATE OF N		MENT OF HEALTH AND I	MENTAL HYGIENE REG. NO.						
1	1. DECEDENT'S NAME (First, Middle, Lest) BEATRICE M		CUFFLEY	2. DATE OF DEATH DAY	10th YEAT 95 11:20 PM					
	4. SOCIAL SECURITY NUMBER 214-14-8770 5. SEX 1 □ M 2 M F	77 YRS. MO	UNDER 1 YEAR IF UNDER 24 HRS. NTHS DAYS HOURS MIN.	7. DATE OF BIRTH (Morth, Day, Year) March 2,19						
TOR	9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN DR LOCATION OF DEATH NORTH ARUNDEL HOSPITAL ASSOCIATION GLEN BURNIE A.A.									
DIRECTOR	10e. STATE 10b. COUNTY									
RAL	10e. STREET AND NUMBER	10g. CITIZEN OF WHAT COUNTRY?								
BY FUNERAL		T EVER IN U.S. ARMED YES 2 NO NAR OR DATES	21146 13. WAS DECENDENT OF HISPAI If yes, specify Cuban, Mexics 1 YES 2 NO Specif	in, Puarto Rican, atc.)	U.S.A. or No. 14. RACE — American Indian, Black, White, etc. Specify: White					
ETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5-	His Do NOT use n	done during most of working	16b. KIND OF BUSII	NESS/INDUSTRY					
COMPL	6	Housewi		Home						
5 8	17. FATHER'S NAME (First, Middle, Last) Clarence Wise			ME (First, Middle, Meiden Si Se Grace Se:						
BE	19a. INFORMANT'S NAME (Type/Print)	19b. MAILING AD	DRESS (Street and Number or Rural							
2	Beatrice Platt	228 Am	beside Drive, S	Severna Par	k, Maryland 21146					
an utu	20s, METHOD OF DISPOSITION 1 Surial 2 Cremation 3 Removal from State 4 Donation 6 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Meadowridge Mem. Park 12-14-95 Baltimore, Maryland									
TO BE COM	22. NAME AND ADDRESS OF FACILITY McCully Funeral Home of Pasadena 21122 3204 Mountain Road, Pasadena, Maryland									
N	23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) DUE TO (OR AS A CONSEDUENCE DF):									
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (DR AS A CONSEDUENCE OF): DUE TO (OR AS A CDNSEDUENCE OF): d.									
Snows any injury. MEDICAL CI	PARTYN. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 MM 1 YE									
AN:	DID TOBACCO USE CONTRIBUTE TO CA			NB						
SICI	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 MO 1 Input lant 2 (1)		(Check only one) THER: Nursing Homa 5 Rasidenca	8 Other (Specify)						
P. E.	27. MANNER OF DEATH 1 Natural 5 Pending 28a. DATE OF (Month, D			28d. DESCRIBE HOW IN	JURY OCCURED					
Z8 IS	2 Accident Investigation 3 Suicide 8 Could not be 4 Homicide detarmined	F INJURY — At home, farm, streatc. (Specify)	et, factory, office	28f. LOCATION (Street an City or Town, State)	nd Number or Rural Route Number,					
ANT: IT ITEM 28 COMPLETE	29a. CERTIFIER (Check only one) 1 CHRIFYING PHYSICIAN: To the best of Dentifying Physician: To the best of a MEDICAL EXAMINER: Dn the best of a MEDICAL EXAMINER: Dn the best of a MEDICAL EXAMINER: Dn the best of a MEDICAL EXAMINER: Dn the best of									
TO BE COMPLE	290 SIGNATURE AND TITLE OF CERTIFIER	endup Do		1684	29d. DATE SIGNED (Month, Day, Year) 12 - 11 - 95					
	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAU CHACKIIMKAI, V. CYRIAC	M.D./1600 C	CRAIN HIGHWAY,	SW/GLEN BUR	RNIE, MARYLAND 21061					
	31. DATE FILED (Month, Day, Year) 32. REGISTRI	AR'S SIGNATURE								

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physic	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.
E HOSPITAL OR AT	E FUNERAL DIRECT	d within 72 hours a	RTANT: If Item 2
TO TH	TO TH	be file	IMPO

FOR 1 - STATE REGISTRAR	STATE OF MARYL	AND / DEPAR	RTMENT OF	HEALTH AND	MENTAL HYGIENI REG. NO.	E			
1. DECEDENT'S NAME (First, Middle, Las Lorraine Ethe					2. DATE OF DEATH DATE DEC.	1995	3. TIME OF DEATH 8:30 A M		
4. SOCIAL SECURITY NUMBER 215-34-8587	(Month Day Year) Country								
96. FACILITY NAME (If not institution, given 71 Honeycomb I				on location of d		9c. COUNTY O	of DEATN imore		
RESIDENCE OF DECEDENT 10a. STATE 10b. COUN	ITY	10c, CIT	ry, TOWN OR LO	CATION			10d. INSIDE CITY		
71 Honeycomb I	ltimore	M	iddle	River			LIMITS?		
10e. STREET AND NUMBER 71 Honeycomb 11. Marital Status 1 Newer Married 2 V Married	Rd.			101, ZIP COOE 21220	10g. CITIZEN OF WHAT COUNTRY?				
11. MARITAL STATUS 1 Never Merried 2 X Merried 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN FORCES? 1 YES	2 NO	If yes	DECENDENT OF HISPA , specify Cuben, Mexico YES 2 NO Specific			RACE — American Indian, Black, Whita, etc. Specify: White		
15. DECEDENT'S EI (Specify only highest gra Elementary/Secondary (0-12) 9 17. FATNER'S NAME (First, Middle, Last)			s USUAL OCCUP work done during ise retired.)	most of working	16b. KIND OF BUS		RY		
17. FATNER'S NAME (First, Middle, Last)		House	жеере		AME (First, Middle, Meiden				
Robert B. Ede	re .				ta Kesle				
19a, INFORMANT'S NAME (Type/Print)	,	19b. MAILING	G ADDRESS (Str		Route Number, City or Town		(e)		
William G. Da	aniels	71 Hc	neyco	mb Rd. E	salt.,MD.	21220)		
20a. METHOD OF DISPOSITION 1 X Burial 2 Cremstion 3 Re 4 Donation 5 Other (Specify)	moval from State	PLACE AND DATE	of disposition	Gardens	DATE 20c. LOC 12/15/19	95 Ba	or Town, State ltimore, MD.		
21. SIGNATURE OF FUNERAL SERVICE	Den Sylvens	hi.	1		Funeral		P.A. ,MD.21221		
23. PART I. Enter the diseases, or shock, or heart failure immediate CAUSE (Finel disease or condition resulting in death) Sequentially list conditions, if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	a. DUE TO (OR AS A DUE TO (OR AS A	consequence of	Cell DF): DF):	mode of dying, such	1 /	lurz	Approximata interval Between Onset and Death		
that initiated events resulting in deeth) LAST	that initiated events DUE TO (OR AS A CONSEQUENCE OF):								
PART II. Other significant condition	PART II. Other significent conditions contributing to deeth but not resulting in the underlying cause given in Part i. 24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 PAO 24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATHY 1 YES 2 PAO								
	ITRIBUTE TO CAUSE O	F DEATH Y	ES NO	☐ UNCERTAL	N 🗆				
DID TOBACCO USE CON 25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLACE OF DEA		one)					
n 1 □ YES 2 □ NO	1 Inpatient 2 ER/Outp	etlent 3 🗆 DOA	OTHER:	Nome 5 Mesidence	8 Other (Specify)				
27. MANNER OF DEATN 1 Natural 5 Pending 2 Accident Investigation	26a. DATE OF INJURY (Month, Day, Year)	28b. TII	JURY	INJURY AT WORK? YES 2 NO	28d. DESCRIBE HOW II	NJURY OCCUR	ED		
3 Suicide 6 Could not t	28e. PLACE OF INJURY building, atc. (Spec		street, factory,	office	28t, LOCATION (Street a City or Town, State)	ATION (Street and Number or Rural Route Number, or Town, State)			
000)	YSICIAN: To the best of my know NER: On the bests of examination						use(s) end manner as stated.		
296. SIGNATURE AND VITLE OF CERTIF	M·D			29c. LICENSE NL	UMBER 487	29d. DATE SIG	GNED (Month, Pay, Year)		
MYO THANT	9101 FRANKE	IN 500		DRIVE,	BALTO, M	n a	1237		
DEC 1 8 1995	32. REGIŞTRAR'S SIGN	ATURE							

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		FilmG, 730, for 1- STATE REGISTRAR	item #1,6 STATE OF MARYL			/95,c			f.h. MENTAL	HYGIENE	Ξ.		720	
		1. DECEDENT'S NAME (First, Middle, Last)							МОИТН	of DEATH DAY	1315	95 8	ME OF DEATH	
3 should		4. SOCIAL SECURITY NUMBER 2.16-24-8097 1 M 2 X F 90. FACILITY NAME (If not institution, give street and number)		(In yrs. lest	A		rs HOURS		8 -	7. DATE OF BIRTH (Month, Day, Year)		Country)	Alabama	
2	DIRECTOR	Meridian Nursing Home-Loch Rave												
ages 1	REC	10e. STATE 10b. COUNTY			10c. CITY, TOWN OR LOCATION								INSIDE CITY	
mit. P		Maryland n/a			Baltimore								YES 2 NO	
ed Jist	ERA	100. STREET AND NUMBER Meridian Nursing Cen- -Loch Raven 8720 Emge Road				ter 101. ZIP CODE 21234				10g. CITIZEN C			COUNTRY?	
ing physician. the burial-transit permit. Pages 1,	BY FUNERAL	11. MARITAL STATUS 1 Never Married 2 Merried 3 X Widowed 4 Divorced 12. WAS DECEDENT EVER IN U.S. AFF FORCES? 1 YES 2/2 IF YES, GIVE WAR OR DATES							HC ORIGINS	RIGIN? (Specify Yea or No— 14. RACE Blact Specific Specific Specific Ricary and Ricary a			mericen Indian, Ne, etc.	
8 2	ED B					CERENTIA HOURS CONTINUE				KIND OF BUILD	NECO (1) (5		Black	
Por co	E COMPLETE	(Specify only highest grade completed) (Gi				CEDENT'S USUAL OCCUPATION ve kind of work done during most of working Do NOT use retired.) Maid				Private Family				
be der									liddle, Meiden S	lle, Malden Surneme)				
s should notified	0 86	19e. INFORMANT'S NAME (Type/Print)		196	. MAILING	Clara Price AlLING ADDRESS (Street and Number or Rural Route Number, C								
De S	F	William Blueford				elle A			Ba1t	imore,	Mar	yland	21207	
		20a, METHOD OF DISPOSITION 1 X Burial 2 Cremation 3 Remov 4 Donation 5 Other (Specify)		netery, crer	natory or oth	NO DATE OF DISPOSITION (Name of vatory or other place)				DATE 20c. LOCATION — City or Town, State				
		Family Lot Dec 18 Gloucester County 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Nutter Funeral Homes,								unty, VA				
0 = 0		Marbet		2501 Gwynns Falls Parkway Baltimore, Maryland 21216					ics, IIIc.					
w requires that the death certificate be executed within 24 hours after the carding physician and completely fifted in by the conformal hygiene prior to burial, cremation, or remova 3 shows any Injury, or other traumatic event, the medical		23. PART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hard failure. List only one cause on each line. Approximats interval Between Onset and Death Onset a												
	CERTIFICATION	Sequentially list conditions, if any, lasding to immediate cause. Entar UNDERLYING CAUSE (Disease or Injury that initiated events resulting in desth) LAST												
	MEDICAL (PART II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in						- 1	24e. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO 2 OF DEATH! 1 YES 2 NO 2 NO 24 NO 24 NO 25 NO 26 NO		ABLE PRIOR TO PLETION OF CAUSE EATH?			
10 6 8 m			USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 🔀								№		40	
E 8 8 E	SICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL: OTHER:												
the the	PHYS	1 VES 2 NO 1	28e. DATE OF INJURY	atlent 3	28b. TIME		INJURY AT	Residence		(Specify)	JURY OCC	CURED		
After this of death with smarked,	ВУ Р	1 Netural 5 Pending (Month, Day, Year) 2 Accident Investigation				M 1 YES 2 NO								
TTENDI CTOR: A after d	8	3 Suicide 6 Could not be 4 Nomicide determined	re, farm, atreet, lactory, office			281. LOCATION (Street end Number or Rural Route Number, City or Town, State)								
TAL OR	COMPLET	29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the best of my knowledge, death occurred at the time, date and place, and due to the cause(e) and manner se stated. 2 MEDICAL EXAMINER: On the best of examination end/or investigation, in my opinion, death occurred at the lime, date and place, and due to the cause(e) and manner se stated.												
TO THE HOSPITAL TO THE FLINEBAL Be filed within 72 IMPORTANT: II	BE	296. SHONATURE AND TITLE OF CERTIFIER	Thipe	na	ren	ì	29c. LIC	30 6	18ER		29d. DATE	E SIGNED (MON	th. Day. Yearsthing 5	
	10	33 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE DE DEATH WITEM 27 (1700. 8mg/ 20 Emgl Rd.												
		31. DATE FILD EUT . 2. 1 8 199!	32. REGISTRAT'S SIGN	ATURE O	really									

BALTIMORE, MARYLAND 21215-9020

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HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed writim 24 hours after	FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the	within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or remove	IANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical
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FUNERAL I TO THE FUNERA be filed within 72 IMPORTANT: II

DIVISION OF VITAL RECORDS, P.O. BOX 6876

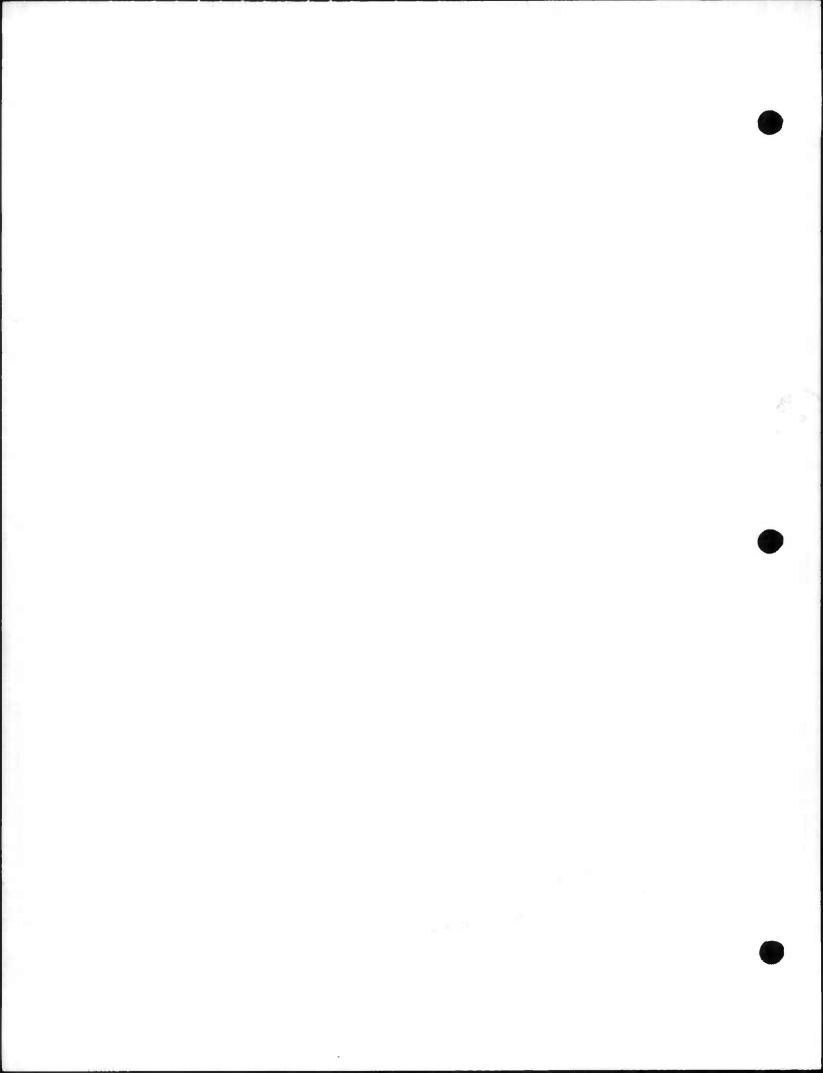
FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH James Madison DVIS 12:30 December 1995 P. M 4. SOCIAL SECURITY NUMBER 5 SEX 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH (Month, Day, Year 8. BIRTHPLACE (State or Foreign Country) IF UNDER 24 HRS. DAYS HOURS 1 X M 2 - F 216-40-1142 53 Aug. 21, 1942 Maryland 9e. FACILITY NAME (If not institution, give street and number, 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH St. Agnes Hospital Baltimore N/A DIRECTOR RESIDENCE OF DECEDENT 10a. STATE 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? Maryland Catonsville Baltimore 1 YES 2 X NO FUNERAL 10a. STREET AND NUMBER 101. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 610 Meyers Drive 21228 U.S.A. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cubsn, Maxican, Puerto Rican, atc.) 11. MARITAL STATUS 14. RACE — American Indian, Black, White, stc. 1 Never Merried 2 Merried 1 YES 2 NO Specify: BY 3 Widowed 4 Divorced White ED 15. DECEDENT'S EDUCATION 16s. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest (Give kind of work done life. Do NOT use retired.) ET Elementary/Secondary (0-12) College (1-4 or 5+) COMPL Writing Specifications State Highway Department 12 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Meiden Surname) James C. Davis Cleo Forrest 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 21228 Mary E. Davis (Spouse) 610 Meyers Drive Catonsville, Maryland 20a. METHOD OF DISPOSITION 20c. LOCATION — City or Town, State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE Buriel 2 Cremation 3 Removal from State John's Cemetery Dec. 19, 195 Donation 6 - Other (Specify) Ellicott City, Maryland TI. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Leroy M & Russell C Witzke Funeral Homes usselle 1630 Edmondson Avenue Catonsville, Maryland 23. PART I. Enter the diseases, or complications that Queed the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, Approximate Interval Batween ehock, or heart fellure. List only one ceuse on eech line. IMMEDIATE CAUSE (Finel (MYOCARDIS/ INFARCTION disease or condition___ 9 2645 resulting in desth) DUE TO (OR AS A CONSEQUENCE OF) CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other eignificant conditions contributing to death but not resulting in the underlying ceuee given in Part I. 24e. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS MEDICAL AWAILABLE PRIOR TO Sepsis COMPLETION OF CAUSE 1 TYES 2 NO OF DEATH? Valvulon heart DISEST 1 TYES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) EXAMINER? HOSPITAL: OTHER: 1 TYES ZY NO 1 Xinpetiant 2 - ER/Outpetient 3 - DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28e. DATE OF INJURY (Month, Day, Year) 27. MANNER OF DEATH 28b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED INJURY Natural 5 Pending 1 YES 2 NO BY Accident Investigation 3 Suicide 26s. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 8 Could not be determined COMPLETED 4 Homicide 29s. CERTIFIER (Check only CERTIFYING PHYSICIAN: To the best of my knowledge, dasth occurred at the time, date end piece, and due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On the basic of examination end/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE December 16, 1995 LETER CAUSE OF DEATH (ITEM 27) (Type, Print) 3449 MO CHN 32 REGISTRAR'S GONTURE

 BALTIMORE, WARYLAND 21215-0020

	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	be filed within 72 hours after death with the State Dept. or Health and Mental Hygiene prior to burial, cremation, or removal.	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 74 hours after death. Page is many he retained by the hospital or attending physician.	
be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other fraumatic event, the medical examiner must be mentioned at once.	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.			DING

							20	00121		
	1 - FOR STATE REGISTRAR	STATE OF MARYLA		RTMENT OF		MENTAL HYGIEN REG. NO				
	1. DECEDENT'S NAME (First, Middle, Last)	S.	Da	u is)	TI	2. DATE OF DEATH MONTH D	3 9 E			
		8. AGE (III	n yrs. lest birthday) YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Morth, Day, Year) Feb. 28,	1017	NRTNPLACE (State or Foreign country)		
1	9a. FACILITY NAME (If not institution, give street			9b. CITY, TOWN	OR LOCATION OF DE		9c. COUNTY	Maryland OF DEATH		
O.	1470 William :	St.		Balto	.City, M	d.	nor	ne		
딥	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY		10c. CIT	TY, TOWN OR LOC	TION			10d, INSIDE CITY		
L DIRECTOR	Maryland nor	ne		lto.Ci	ty,Md.			LIMITS? 1 X X ES 2 NO		
RA		William S		,	21230			of what country? ed States		
FUNERAL		2. WAS DECEDENT EVER IN	U.S. ARMED	13. WAS DE		IIC ORIGIN? (Specify Yes				
BY	1 Never Married 2 Married 3 Wildowed 4 Divorced	FORCES? 15 YES IF YES, GIVE WAR OR DA Army	2 NO TES	If yes, s		n, Puerto Ricen, etc.))	RACE American Indian, Black, White, etc. Specify: White		
	15. DECEDENT'S EDUCAT (Specify only highest grade co.	TION	16a, DECEDENT'S	USUAL OCCUPAT	ION ost of working	16b. KIND OF BUS	SINESS/INDUST	RY		
COMPLETED		College (1-4 or 5+) NONE	Ille. Do NOT u	efighte		Ba1	to.Cit	cy,		
00	17. FATHER'S NAME (First, Middle, Last)					ME (First, Middle, Maiden				
BE		e S.Davis,			Thelma			avis Brown		
2	19a. INFORMANT'S NAME (Type/Print) Mr. Claude S. Dav	ic Tr				alto.Md.				
	20a. METHOD OF DISPOSITION	20h	PLACE AND DATE	OF DISPOSITION //			CATION — City			
	1 Donation 5 ☐ Other (Specify)	I from State ceme	tery, crematory or o	other placel		6/95 Ba	•			
	21. SIGNATURE OF FUNERAL BETWICE LICEN	SEE		22. NAME /	ND ADDRESS OF FA	Balto	.Md. 2			
\vdash	Caron Lange	mella that are a	the death De-		_					
CERTIFICATION	23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, abock, or heart feliure. List only one cause on sech line. IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentielly list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):									
MEDICAL C	PART II. Other algnificant gonditions of	contributing to death bu	t not resulting	in the underlyli	g ceuse given in	AUTOPSY MED? NO	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF GEATH?			
	DID TOBACCO USE CONTRIE	BUTE TO CAUSE OF	DEATH YE	ES NO [UNCERTAIN	10		1 YES 2 NO		
SICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	IOSPITAL:	6. PLACE OF DEA	TH (Check only the			- 11			
YSI	1 VES 2 NO 1	☐ Inpatient 2 ☐ ER/Oulpa	tient 3 🗆 DOA	OTHER: 4 Nursing No	ne 5 🗆 Rasidence	6 Other	3 Ha	SPICE		
РНУ	27. MANHEN OF SEATH 1 Pending	28s. DATE OF INJURY (Month, Day, Year)	26b. TIM	JURY W	JURY AT ORK?	28d. DESCRIBE HOW B	LIURY OCCURE	4		
ВУ	2 Accident Investigation 3 Suicide & Could not be	28s. PLACE OF INJURY	- At home, farm,		YES 2 NO	261. LOCATION (Street a	nd Number or Br	rral Brusta Number		
밀	3 Suicide 6 Could not be 4 Homicide determined	building, etc. (Specif	(v)			City or Town, State)	nd Nomber of Al	ner ricite Notices,		
COMPLETED	29a. CERTIFIER 1 CERTIFYING PNYSICIAL (Check only one) 2 MEDICAL EXAMINER: 0									
ECC	296. SIGNATURE AND TITLE OF CEATIFIER		1 -		29c. LICENSE NUM		29d. DATE SIG	_		
TO BE	30. NAME AND ADDRESS OF PERSON WHO C	e, M	2,		113	0/2	1/3	12095		
	105/05 MICHAYN	OMPLETED CAUSE OF BEA	TH (ITEM 27) (Type)	Huma	in M	11 2	1204	Payne (PA)		
	ST. DATE FILED (MOORN, Day, 1997) DEC 1 8 1995	A PEGISTRAR SIGN	W.E		1	· · · · ·		9.00		





State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth December 13, 1995 10:30AM RUTH **ENGLAR** 4e. Facility Neme (If not Institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Anne Arundel Pasadena 8192 Waterford Road 7. Age (In yrs. last birthdey) If Under 1 Year If Under 24 Hrs.

Months Deys Hours Min. 8. Dete of Birth (Month, Dey, Year) Birthplece (State or Foreign Country) 1□M 2⊠F Vrs October 21,1928 Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits Pasadena 1 ☐ Yes 2 No Anne Arundel 10f. Zip Code 10g. Citizen of What Country? 21122 U.S.A. 8192 Waterford Road 14. Race - American Indian, Bieck, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 No 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: White 3 ☐ Widowed 4 ☐ Divorced 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Home Housewife 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surname) Marian Forwood Oscar Redmond 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code, 8192 Waterford Road, Pasadena, Maryland 21122 Franklin Englar 20b. Piece of Disposition (Name of cemetery, cremetory or other piece) 20c. Location - City or Town, State Dete 1 ☐ Burial 2 MCremetion 3 ☐ Removei from Stete Metro Crematory Inc. 12-14-95 Catonsville, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licenses 22. Name end Address of Fecility McCully Funeral Home of Pasadena ancis S. Karczmarek 3204 Mountain Road, Pasadena, Maryland 21122 23a. Perf1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dylng, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line. 4eass carcinoma of lung Due to (or es e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were sutopsy findings eveilable prior to completion of ceuse of death? 24e. Wes an eutopsy performed? 1 Yes 2 No 1 Yes 2 No 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Presidence 8 Other (Specify) 1 Inpatient 2 ER/Outpetient 3 DOA 28a. Dete of Injury (Month, Dev Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? 1 Yes 2 No

Physician /Medical Examiner Box 68760.

Physician

/Medical

Examiner

Funeral

Director

7 is manked other than "natural", or items 23s or 28e-f sho traumstic event, the Medical Examiner must be notified at

s filed within 7 al Hyglene. 3 other then "n

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is mented other any finjury or other trassments.

Saltimore, Maryland 21215-0020

5. Sociel Security Number

Maryland

10e. Street end Number

20e. Method of Disposition

Immediete Ceuse (Finel diseese or condition resulting in deeth)

Sequentielly list conditions, if any, leeding to immediate ceuse. Enter Underlying Cause (Diseese or injury that initieted events resulting in deeth) Lest

11. Meritel Stetus

10a. Stete

Director

Funeral

þ

Completed

Be

2

212-26-6268

Usuel Residence of Decedent

Examiner Physician/Medical þ Completed P

ician and burial-transit physician as the burial ed by the a Deen page 2 s has certificate funeral Certification: 2 edicai

Records, P.O.

Division of Vital

 Hospital or Attanding Physician:
 24 hours after death.
 Funeral Director: After this certifica To the twithin 2
To the f

State Registrar 25. Wes case referred to medical examiner? 1□ Yes 2□ No 27. Menner of Deeth 1 DNatural 5 Pending Investigation 2 Accident 3 ☐ Sulcide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 29e. Certifier 19 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end piece, end due to the cause(s) end menner es stated. (Check only one) 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date end piece, end due to the cause(s) end menner steted.

29b. Signeture and Tile of Carl flor 29d. Date signed (Month, Day, Year)

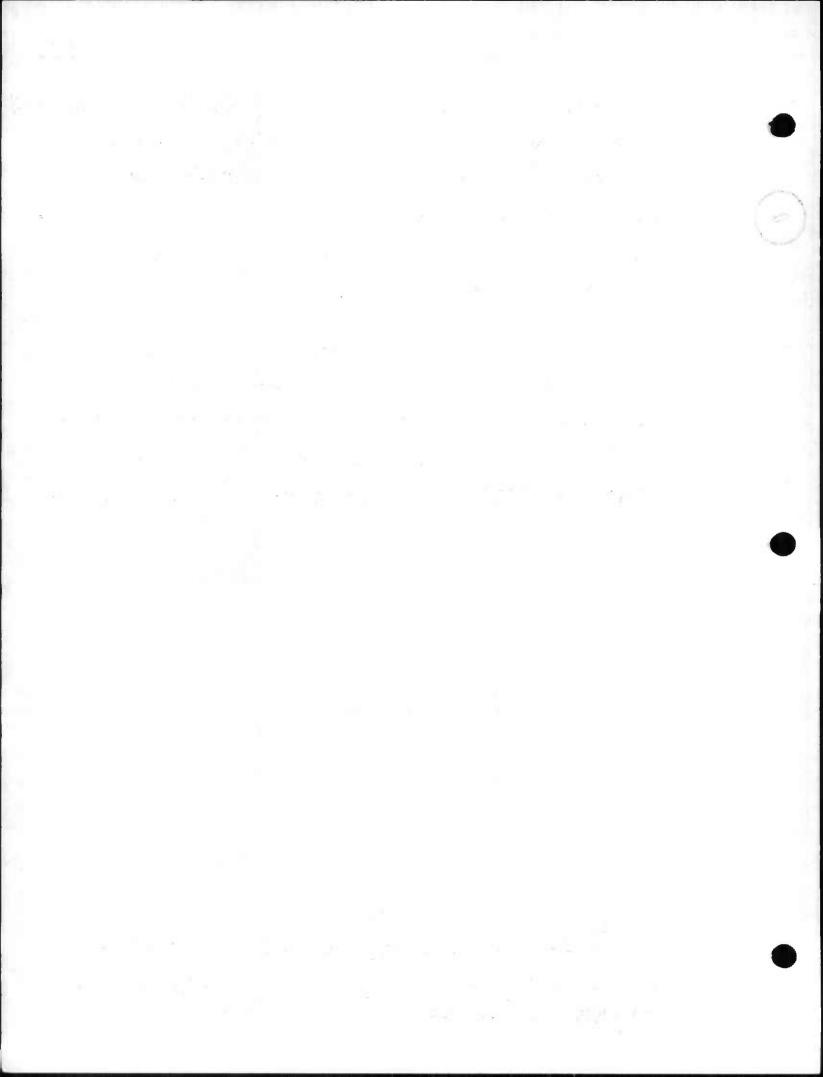
MD

30. Neme end address of person who completed cause of deeth (Item 23e) (Type, Print)

Crusmost - S. Sawhney MD, 3 21 Date filed (Month, Day, Year) 32, Redistress Signeture , 325 Hospital Drive 202, MD-21061. 31. Dete filed (Month, Day, Year)

DEC 1 8 1995

June Randal



TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bund-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	FOR STATE REGISTRAR	STATE OF MARYLAND	/ DEPART	MENT OF H	EALTH AND	MENTAL HYGIE		٠		
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH			TIME OF DEATH	
ľ	Jean R.	Fisher				Dec. 15,	1995	YEAR	8:30 a M	
		5. SEX 6. AGE (In yrs.		IF UNDER 1 YEAR	IF UNDER 24 HRS, HOURIN MIN.	7. DATE OF BIRTH (Month, Day, Year)		8. BIRTHPLA Country)	CE (Stete or Foreign	
		1 □ M 2 🖁 F 6	5 YRS.			Nov. 1,		Penn		
œ	90. FACILITY NAME (If not institution, give stre				R LOCATION OF D	EATH		TY OF DEATI	1	
DIRECTOR	1011 Bowley's Quar	ters Road		Middle	River		Balti	ımore		
E	10a. STATE 10b. COUNTY		10c. CITY,	TOWN OR LOCAT	ION			100	I. INSIDE CITY LIMITS?	
	Maryland Baltim	nore		Middle				1 [YES 2 NO	
FUNERAL	10e. STREET AND NUMBER			10f	ZIP CODE		10g. CITIZ	EN OF WHAT	COUNTRY?	
NE	1011 Bowley's Quar	ters Road 12. WAS DECEDENT EVER IN U.S. /	101150	T 40 1111 0 000	21220			J.S.A.		
	1 Never Married 2 Married	FORCES? 1 YES 2		If yes, sp	cify Cuban, Mexico	NIC ORIGIN? (Specify in, Puerto Rican, etc.)		Black, W	Americen Indian, hite, etc.	
BY	3 Widowed 4 Divorced	IF TES, GIVE MAN ON DATES		I L TES	2 X NO Specif	у.		Specify:	hite	
COMPLETED	15. DECEDENT'S EDUCA (Specify only highest grade of	ATION 18e. (SUAL OCCUPATION		16b, KIND OF	BUSINESS/INDI	USTRY		
	Elementery/Secondary (0-12)	College (1-4 or 5+)	life. Do NOT use	retired.)	•					
MP	17. FATHER'S NAME (First, Middle, Last)		Housew	ife			Home			
	Howard S. Henning					ME (First, Middle, Meid	ion Surneme)			
BE	19e. INFORMANT'S NAME (Type/Print)		19b. MAILING /	OORESS (Street e		Rock Route Number, City or	Town, State, Zip	Code)		
10	Deborah L. Jenning	ıs 4	1 Dogw	ood Dri	ve Middl	e River,	Marvla	and 21	220	
İ	20e. METHOD OF DISPOSITION 1 X Burlel 2 Cremation 3 Ramon	20h PLAC	FANDDATEO	DISPOSITION/Na	me of	DATE 20c.	LOCATION - C	lity or Town	State	
	4 Donation 5 Other (Specify)	Holly	y Hill	Mem. Ga	ardens 1	2/16/9\$Ba	ltimor	e Co.	, Maryland	
	21. SIGNATURE OF FUNERAL SERVICE LICE	INSEE		Bruzd	o acoress of FA Zinski F	uneral Ho	ome P.A	١.		
	Da- 12	-dr	4						and 21221	
	23. PIRT I. Enter the diseases, or co shock, or heart fallure. L	omplications that caused the lat only one cause on each if	daath. Do no na.	1 enter the mo	de of dying, euc	h as cardiac or re	apiratory arre	est,	Approximata Interval Between	
	IMMEDIATE CAUSE (Final disease or condition	(,						Onset and Death	
	resulting in death)	DIE TO (OR AS A CONS	etes							
		I /m	SECULENCE OF,	11.000	bucca					
CERTIFICATION	Sequentially list conditions, if any, leading to immediate	DUE TO (OR AS A CONS	EQUENCE OF	4 y per	CKITOK					
CA	cause. Enter UNDERLYING CAUSE (Disease or injury	c								
E	that initiated eventa resulting in death) LAST	DUE TO (OR AS A CONS	SEQUENCE OF)							
SER	d.									
AL	PART il. Other significant conditions	contributing to death but no	t rasulting in	the underlyin	g cause givan in		AN AUTOPSY FORMEO?		RE AUTOPSY FINDINGS	
DIC			_			1 🗆 YES	20 NO	co	MPLETION OF CAUSE DEATH?	
ME								1 [YES 2 NO	
PHYSICIAN: MEDIC	DID TOBACCO USE CONTR			(Check only one)	UNCERTAI	NET				
SICI	EXAMINER?	HOSPITAL: 1 Inpatient 2 ER/Outpatient		OTHER:		8 Other (Specify)				
HYS	27. MANNER OF DEATH	28a. DATE OF INJURY	28b. TIME	OF 28c. INJ	URY AT	28d. DESCRIBE HO	W INJURY OCC	URED		
	1 Natural 5 Pending	(Month, Day, Year)	INJU		PRK? YES 2 NO					
ED BY	2 Accident investigation 3 Suicide 8 Could not be	28e. PLACE OF INJURY — At building, etc. (Specify)	home, larm, st	eat, factory, offic	•	281. LOCATION (Street and Number or Rural Route Number, City or Town, State)				
ETE	4 Homicide determined	1123								
COMPLET	and and	CIAN: To the best of my knowledge,								
Š	2 MEDICAL EXAMINER	R: On the basis of examination end/	or investigation	, in my opinion, d	eath occured at the	time, date end placa	, end due to the	e ceuse(s) an	d menner es stated.	
BE (296. SIGNATURE AND TITLE OF CERTIFIER	. (29c. LICENSE NU	MBER	29d. DATE	SIGNEO (Ma	oth, Day, Year)	
5	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CALIFE OF DEATH I	TEM 270 /3	Turing 1	D34	(49.		12/	15/85	
	2 1/2 DILLIMA	ILL ALLE	A . 1/	or Ud	2/2	223				
	31. DATE FILEO (Month, Day, Year)	32. REGISTRAR'S SIGNATURE	NXA+C	- VIG	1-1					
	DEC 1 8 1995	in Davidear Rardall								
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3. TIME OF DEATH

REG. NO.

2. DATE OF DEATH

FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

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December 15,1995 Vernon George Forrest 11:04 A 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. lest birthday) 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign IF UNDER I YEAR IF UNDER 24 HRS. 213-18-7814 1 X M 2 - F 76 YAS. Dec. 15, 1919 Maryland permit. Pages 1, 2, 3 should 9e. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH Maryland General Hospital DIRECTOR Baltimore City Baltimore City RESIDENCE OF DECEDENT 10c. CITY, TOWN OR LOCATION 10a. STATE 10b. COUNTY 10d. INSIDE CITY n/a Maryland Baltimore 1X YES 2 NO FUNERAL 10e. STREET AND NUMBER 10g, CITIZEN OF WNAT COUNTRY? use as the bunal-transit 1100 Bolton Street Apt. 312 21201 USA within 24 hours after death, Page 6 may be retained by the hospital or attending physician. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-If yes, specify Cuban, Mexican, Puerto Rican, atc.)

1 YES 2 A NO Specify: 14. RACE — American Indian, Black, White, atc. 1 Never Married 2 Married Specify BY 3 🔀 Widowed 4 🗌 Divorced Black 16e. DECEDENT'S USUAL OCCUPATION ETED 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only higher (Give kind of work done life. Do NOT use retired.) 10¢ Elementary/Secondary (0-12) College (1-4 or 5+) COMPL High School Stock Clerk Well-Made Pants Manufacturer once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) funeral director, page 5 should be Ħ Marshall Forrest Frances Williams notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Gladys Forrest 2115 Penrose Avenue Baltimore, MD 21223 must be 20s. METHOD OF DISPOSITION
1X) Burlel 2 Cremetion 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State 4 Donation 5 Other (Specify) Dec 21 Baltimore County, MD Arbutus Memorial Park examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Nutter Funeral Homes, Inc. 2501 Gwynns Falls Parkway Nun alke Baltimore, Maryland 21216 filled in by the fion, or removal. medical 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. interval Between Onset and Death **IMMEDIATE CAUSE (Final** the cremation, disease or condition Cardiac Arrythmia 1 hour completely resulting in death) other traumatic event, DUE TO (OR AS A CONSEQUENCE OF): executed bunal, CERTIFICATION and Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): this certificate has been signed by the attending physician a with the State Dept. of Health and Mental Hygiene prior to If any, leading to immediate cause. Enter UNDERLYING certificate CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated avents resulting in death) LAST 6 death (Injury, PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24e. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS MEDICAL PERFORMED? AVAILABLE PRIOR TO that 23 shows any COMPLETION OF CAUSE OF DEATH? Hypertension 1 TYES 2 THO requires 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: MP 28. PLACE DF DEATH (Check only one) 25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL: OTHER:
4 Nursing Home 5 Residence 8 Other (Specify) t ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA OR ATTENDING PHYSICIAN: 0 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d, DESCRIBE HOW INJURY OCCURED marked, 1 Natural
2 Accident TO THE HOSPITAL OR ATTENDING PHIOTO TO THE FUNERAL DIRECTOR: After this be filed within 72 hours after death will IMPORTANT; If Item 28 is market 5 Pending 1 YES 2 NO BY investigation 3 Sulcide 28a. PLACE OF INJURY — At homa, farm, street, fectory, offica building, atc. (Specify) 281. LOCATION (Street and Number or Rural Route Number City or Town, State) 8 Could not be determined COMPLETED 29a. CERTIFIER (Check only | CERTIFVING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and placa, and dua to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and piece, and due to the cause(s) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29d. DATE SIGNED (Month, Day, Year)

December 15,1995 29c, LICENSE NUMBER 89234 Damar 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type. Print) Shakir Sarwar, M.D. c/o Maryland General Hospital 31. DATE FILED (Month, Day, Your) 32. REGISTRAR'S SIGNATURE 8 1995

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

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	Pages 1		
hysician.	director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3		
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dill. re	illed in by the funeral di		marked or item 23 shows any injury or other fraumatic event the medical examiner must be notified at once
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MP am	a has t	e Dept	m 23
I'WW.	rificate	tter death with the State Dept. of Health and Mental Hygiene prior t	or its
G PRIOR	this ce	with th	head
DING	After	death	e ma
ALIEN	ECTOR	be filed within 72 hours after death	IDODTANT If Hem 28 is a
AL UK	AL DIRI	2 hour	M Han
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	1 - STATE OF MARYL REGISTRAR	AND / DEPAR CERTIF	TMENT OF HEAL ICATE OF DE	TH AND M	ENTAL HYGIEN					
	1. DECEDENT'S NAME (First, Middle, Last)	100			2. DATE OF DEATH	MY YEAT				
	A LMA GRANDS			\rightarrow	12-5	95	UNKNOWN			
	220-22-7625 1 □ M 2 M F 6	In yrs. last birthday) YRS.	MONTHS DAYS HOU		7. DATE OF BIRTH (Month, Pay, Year) 0 1-16-2	6 0	RTHPLACE (State or Foreign unitry)			
œ	9a. FACILITY NAME (If not institution, give street and number)		9b. CITY, TOWN OR LO	,	TH	9c. COUNTY O				
OT:	PESIDENCE OF DECEDENT		MIDDLE	RIVER		BALT	IMORE!			
DIRECTOR	MARYLAND BALTIMOR		y, town or location MIDDLE	RIVER			10d. INSIDE CITY LIMITS? 1 YES 2 70			
FUNERAL	10s. STREET AND NUMBER		10f. ZIP (CODE		10g. CITIZEN O	F WHAT COUNTRY?			
NE				-12	20	14	S. A			
		2 XX10	If yes, specify (Cuban, Maxican,	ORIGIN? (Specify Ye Puerto Rican, atc.)	В	ACE — American Indian, lack, White, etc.			
ВУ	3 SWidowed 4 Divorced IF YES, GIVE WAR OR D	ATES	1 - YES 2 X	NO Specify:		Los	HITS			
ED	15. DECEDENT'S EDUCATION (Specify only highest grade completed)	16a. DECEDENT'S	USUAL OCCUPATION work done during most of w	orkina	16b. KIND OF BU	ISINESS/INDUSTR	1			
COMPLETED	Elementary/Secondary (0-12) College (1-4 or 5+)	life. Do NOT u	se retired.)							
MP	11		HOUSEWIF				WN HOME			
BE CO	17. FATHER'S NAME (First, Middle, Last) CLAUDE TAYLOR			BESSIE	E (First, Middle, Maider WILLIAMS					
0	19a. INFORMANT'S NAME (Type/Print)		ADDRESS (Street and Nu							
	JUDY HERBERTTA TREUTH 20s. METHOD OF DISPOSITION		NGLEWOOD ROAD			CATION — City of				
	1 X X Burial 2 Cremation 3 Removal from State	etery, cremetory or o	ther place)							
	21. NAME AND ADDRESS OF FACILITY									
	BRUZDZINSKI FUNERAL HOME P.A. 1407 EASTERN AVE. BALTIMORE, MARYLAND 2									
-	23. PART I. Enter the diseases, or permanent of that caused	I the death De					D 21221 Approximate			
TION	ahock, or heart fuller. List only one cause on each line. IMMEDIATE CAUSE (Finel disease or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):									
CERTIFICATION	cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated eventa reculting in deeth) LAST d.									
PHYSICIAN: MEDICAL C	PART II. Other eignificant conditions contributing to deeth b	In the underlying cau	n the underlying cause given in Part I.			24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO				
	DID TOBACCO USE CONTRIBUTE TO CAUSE C	F DEATH Y	ES NO U	NCERTAIN						
CIAI	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PLACE OF DEA	TH (Check only one)							
/SI(1 YES 2 NO 1 Inpatient 2 ER/Outs	petient 3 DOA	OTHER: 4 Nursing Home 5	Nasidence 6	Other (Specify)					
PH	27. MANNEB OF DEATH 28a. DATE OF INJURY (Month, Day, Year)	28b. TIN	JURY 28c. INJURY A	AT .	28d. DESCRIBE HOW	INJURY OCCURED				
ВУ	1 Netural 5 Pending 2 Accident Investigation		M 1 TES	2 NO						
COMPLETED	3 Suicide 8 Could not be 4 Homicide determined 226s. PLACE OF INJURY building, etc. (Special Country of the Cou	— At home, ferm,	etrest, factory, office 281. LOCATION (Street and Number or Rural Route Number, City or Yown, State)							
PLE	29a. CERTIFIER (Check only 1 CERTIFYING PHYSICIAN: To the best of my know	ledga, daeth occurr	red at the time, data and p	olaca, and dua 1	o the cause(a) and me	inner as stated.				
O.	one) 2 MEDICAL EXAMINER: On the beals of examinetion	n and/or investigation	on, in my opinion, death o	occured at the t	lme, data and place, a	nd dua to the cau	e(a) and manner as stated.			
BE	201 STATUTE AND TITLE OF CERTIFIER		290	LICENSE NUME	F100	29d. DATE SIGN	NED (Month, Day, Year)			
2	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DE	ATH (ITEM 27) (Type	0	0.0						
	-1150LOUKEMS	KOAC	BAL	111	D 2/2	20.				
	DEC 1 8 1995 Julia Sturber Ran	ATURE								

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DIVISION

	STATE OF MARYLAND / DEPARTMENT OF HEALTH AND	MENTAL HYCIENE	-	8132
TE BISTRAR	CERTIFICATE OF DEATH	REG. NO.		
ENT'S NAME (First, Middle, Last)		2. DATE OF DEATH		3. TIME OF DE

	1 · STATE OF STATE OF	MARYLAND / DEPAR	TMENT OF H	EALTH AND	MENTA	L HYGIEN	E				
	1. DECEDENT'S NAME (First, Middle, Last)					OF DEATH		3.	TIME OF DEATH		
	Albert Gord	on			MONT		14.19	EAR	7:01a M		
	4. SOCIAL SECURITY NUMBER 5. SEX	5. SEX 6. AGE (In yrs. last birthday) IF UNDER t YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTH									
	389 03 5774 1♀№2□F	85 YRS.	MONTHS DAYS	HOURS MIN.		i15.		Country) Ru	ssia		
	9e. FACILITY NAME (If not institution, give street and number)			R LOCATION OF D	-		9c. COUNTY				
DIRECTOR	Hebrew Home of Greater Washington Rockville Montgomery										
REC	10e. STATE 10b. COUNTY	10c. CITY	, TOWH OR LOCAT	ION				10	d. INSIDE CITY		
	Maryland Montgomery	Ch€	evy Cha	se				1 [YES 2 NO		
FUNERAL	10e. STREET AND NUMBER		101	. ZIP CODE			10g. CITIZEN	OF WHA	T COUNTRY?		
NEI	8100 Connecticut Aven			20815			USA				
BY FU	1 Never Married 2 Married FORCES?	TEVER IN U.S. ARMED 1 YES 2 NO WAR OR DATES	If yes, sp	ENDENT OF HISPA acify Cuban, Mexica 2 🔯 NO Specific	an, Puerto I	i? (Specify Yes Rican, etc.)	or No— 14.	RACE — Black, W Specify:	American Indian, fhits, etc.		
	3 Widowed 4 Divorced						W	hit	е		
COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed)	16a. DECEDENT'S (Give kind of w	ork done during ma		16b	KINO OF BUS	INESS/INDUST	RY			
芦	Elementery/Secondary (0-12) College (1-4 or 5							-			
ME	17. FATHER'S NAME (First, Middle, Last)	Food Di	stribu			ish a		ult	ry		
E C	Isadore Gordon			16. MOTHER'S NA	-						
0	19a. INFORMANT'S NAME (Type/Print)	19b MAILING	ADDRESS (Street o	Sarah			~	efe l			
2	Elizabeth Gordon Blun	tschli Fast	2 Oakl	and S Ci	ircl	e e	r, Srana, Zip Coc	10)			
	20a. METHOD OF DISPOSITION	20b. PLACE AND DATE O		ryland_	DAT		CATION — City	or Town.	State		
	1 1 Buriel 2 Cremation 3 Removal from State 4 Donation 6 Other (Specify)		m - Gdn	s 12	/ 1:7 /	95 01	nav	Mar	v1and		
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE	4	22. NAME AN	D ADDRESS OF FA	ACILITY				VIAIIU		
	June tru Parl	u		Pearson				S			
	23. ART I. Enter the diseases, or complications th	at caused the death. Do n	ot enter tha mo	Church de of dyling, auc	ch es card	fiac or reaph	U 4 6 ratory arrest,		Approximata		
	ahock, or heert fallure. List only one ca IMMEDIATE CAUSE (Final	use on each line.							Interval Between Onset and Death		
		CINOMA O (OR AS A CONSEQUENCE OF	BF	LUN	a				3 YEARS		
	OUE TO	O (OR AS A CONSEQUENCE OF):						0/2/12		
Z	Sequentially list conditions,										
ATI	If any, leading to immediate cause. Enter UNDERLYING	O (OR AS A CONSEQUENCE OF):								
CERTIFICATION	CAUSE (Diseese or injury	O (OR AS A CONSEQUENCE OF):								
E	resulting in death) LAST										
	DART II Oh - I - We - A - We - A										
SAL	ASHD, ASCVD	o deeth but not resulting in	the underlying	ceuse given in	Part I.	24s. WAS AN / PERFORI		AW	RE AUTOPSY FINDINGS AILABLE PRIOR TO		
ă	HOHD, ASCUL					1 TES 2	APNO	co	MPLETION OF CAUSE DEATH?		
M	DID TOPACCO LICE CONTRIBUTE TO C	ALICE OF BEATLE VE			ابد		ĺ	1 [YES 2 NO		
AN	DID TOBACCO USE CONTRIBUTE TO CA	26. PLACE OF DEATH		UNCERTAIL	N X						
PHYSICIAN: MEDIC	EXAMINER? HOSPITAL:		OTHER:			- 318370m					
H	27. MANNER OF DEATH 26a. DATE O			5 Residence		r (Specify) CRIBE HOW IN	LIURY OCCUR	ED.			
	1 Netural 5 Pending	Day, Year) INJL	JRY WO								
) BY	3 Suicide 28a. PLACE	OF INJURY A1 home, ferm, at	reet, fectory, offici			ATION (Street a	nd Number or F	lural Route	Number,		
E	4 Homicide determined	j, atc. (Specify)			City	or Town, State)					
PLE	29a. CERTIFIER (Check only CERTIFYING PHYSICIAN: To the bast of	of my knowledge, death occurre-	d at the time, date	end place, end due	to the cau	se(s) and men	ner as stated.		====		
COMPLETED	one) 2 MEDICAL EXAMINER: On the basis of							use(s) sn	d manner as stated.		
	290. SIGNATURE AND TITLE OF CERTIFIER	van e		29c. LICENSE NUI					onth, Day, Year)		
D BE	steven Ly	son 1	10	D 0:	588	35	1121	1,4	195		
2	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAL	JSE OF DEATH (ITEM 27) (Type,	Print)	1	7	1					
	STEVEN LIPSON		NTRO	SE R	ν_{i}	KOC	KUI	22.	E		
	31. DATE FILED (Month, Day, Year) 32. REGISTR	AR'S SIGNATURE									
	UEC 1 8 1995 This Mentes	charlall									
	7	- 64							DHMH-16 Rev 1/89		

100 Connecticut Avenue,

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Fish and Poultry

Food Distributor

Isadore Gozdon

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Saraj Savrensky

Elizabeth Gordon Bluntschli Easten, Maryland 21601

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Judean Mem. Gdns 12/17/95 01-

Ives-Pearson Funer Falls Church, VA Sumstrie Parler

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within any found and death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Merial Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR 1 - STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAR		CI	ENTIF	ICALE	Ur	DEA	П		REG. NO.			
	1. DECEDENT'S NAME (First, Middle, Last) Robert Sherman				Hill, Jr. 2. DATE OF DEATH MONTH NOV					DA	DAY 1995 1210 M		
	4. SOCIAL SECURITY NUMBER 218-05-8980	5. SEX 1 🖔 M 2 🗆 F	6. AGE (In yrs. las	t birthday) YRS.	IF UNDER	1 YEAR DAYS	IF UNDER	24 HRS.	7. DATE OF (Month, D June	BIRTH ny, Year)			
	Sa. FACILITY NAME (If not institution, give s	treet and number)			9b. CITY,	TOWN (OR LOCATI	ON OF DE		7, 1		INTY OF DE	
DIRECTOR	PENINSULA REG		ICAL CE	NTER			SALI	SBUR	Υ			WICOM	ICO
DIRE	Maryland Wicon			10c. CIT	y, town o Salis	bur	y y						IOd. INSIDE CITY LIMITS?
FUNERAL	P.O. Box 731					101	2180.	3-07:	31			S.A.	HAT COUNTRY?
BY	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT FORCES? 1 IF YES, GIVE W	X YES 2 P	MED 10	l H	yes, sp	ENDENT Cooling Cube	n, Maxicar	IIC ORIGIN? (S n, Puerto Rice	ipecify Yes n, etc.)	or No-	14. RACE - Black, Specify.	- American Indian, Whita, etc. White
TED	15. DECEDENT'S EDU (Specify only highest grade		16a. DE	CEDENT'S	USUAL OC	CUPATIO	ON st of working	10	16b, Kil	ND OF BUS	INESS/IN	DUSTRY	
COMPLETED	Elementary/Secondary (0-12)	College (1-4 or 5 +	' I	DO NOT U					Dro	KO H	Indu	strie	A
Ö	17. FATHER'S NAME (First, Middle, Last)	0.0	110	reemai	L		18, MOTI	HER'S NA	ME (First Midd			soure	3
BE (Robert Sherman Hi												
5	18a. INFORMANT'S NAME (Type/Print) ((Mildred Hill	vege)							ioute Number. y, Mar			1803-	0731
	20a. METHOD OF DISPOSITION 1 □ Burlel 2 □ Cremation 3 □ Rem 4 ☒ Donation 5 □ Other (Specify)	oval from State	20b. PLACE / cemetery, cre	AND DATE	OF DISPOSI				DATE	-		City or Town	n, State
	21. SIGNATURE OF FUNERAL SERVICE LIC	enseeJoseph	B. yan	Sant									ore Street 1-1559
	22. PART I. Enter the diseases, or o	complications that	caused the de	ath. Do r					-	400			Approximate
	snock, or neert tenure.	List only one caus	se on each line										Interval Between Onset and Death
	disease or condition a. Congest TIVE HEART FAILURE for month										few months.		
z	- Astraios de on												
CERTIFICATION	Sequentially list conditions, If any, leading to immediate cause. Enter UNDERLYING												
FIC	CAUSE (Disease or Injury that initiated events	OUE TO (OR AS A CONSEC	DUENCE OF	j:								
ERI	resulting in death) LAST	1											
	PART II. Other algnificant condition	s contributing to	death but not r	esulting	n the un	derlying	ceuse ç	lven in f	Part I. 24	n. WAS AN			VERE AUTOPSY FINDINGS
EDICAL	Renal Failur	e se	hydral	on, Jaundice, 1 yes:							0	MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?	
Σ	MF- LOSS,		ICE OF DEA	TIL VE	<u>- </u>	10 [1 11110					1	YES 2 NO
PHYSICIAN:	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 26. PLACE OF DEATH (Check only one)												
YSIC	EXAMINER? 1 YES 2 NO	HOSPITAL:	ER/Outpatient 3	□ DOA	OTHER 4 Nursi		• 5 □ Re	sidence (Other (Sp	pecify)			
ВУ РН	27. MANNER OF DEATH 1 Netural 5 Pending 2 Accident Investigation	28a. DATE OF I (Month, Day		28b. TIM INJ	E OF URY M	28c. INJI WO 1 Y			28d. DESCRI	BE HOW IN	JURY OC	CUREO	
8	2 Acceptant 3 Suicide 8 Could not be determined 4 Homicide Could not be determined 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 28b. LOCATION (Street and Number or Rural Route Number, City or Town, State)									rte Number,			
COMPLET		CIAN: To the best of n											and manner as stated.
BE CC	295. SIGNATURE AND TITLE OF CERTIFIED	690	-				29c. LICE	NSE NUM	BER	Т	29d. DAT	E SIGNED (A	fonth, Day, Year)
2	30. NAME AND ADDRESS OF PERSON WH	LETED CALISI	E OF DEATH (ITEN	1 27) /Tune	Print)		بر	180	014		_	11-2	7.93
	DEEPAK SAGGAY,	10.0.	541E	RIVE	15105	a	1 3	ALKE	wy.	no.	2/80	11	7.95
	31. DADEC 110180-1995	T. P. WELLAND	S'SINGETH ET						/				

	Ag o	ne bor		
100 C 1 C 1 C 1 C 1 C 1 C 1 C 1 C 1 C 1	TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending and	TO THE FUNEAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the fundamental director, page 5 should be detached for use as the fundamental director, and the following the followin		
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	eath. P	uneral		amin
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	hours	lled in	1, Or re	э шед
	ithlit 24	letely fi	emation	nt, th
	w betu:	Сотр	ırial, cr	Ic eve
	be exec	ian and	or to be	анта
	tificate	physic	ene pri	ther tr
	ath cer	ttending	al Hygi	, or o
•	the de	y the a	Ment	Injury
	es that	gned by	afth an	s any
	requir	been si	. of He	show
	The law	te has	te Depi	вт 23
	CIAN	ertifical	the Sta	or He
	PHYS	r this c	h with	arked,
	ENDING	R: Afte	er deat	E S
	DR ATT)IRECTO	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.
	PITAL (ERAL D	in 72 h	T. H 18
	IE HOS	IE FUN	d withi	BTAN
	10	10	be file	MP

	1 - STATE REGISTRAR	STATE OF MARYL	AND / DEPART	MENT OF I	EALTH AND	MENTA	L HYGIEN	E				
	1. DECEDENT'S NAME (First, Middle, Lest) MAISIE M.	HUGHES				MONT	OF DEATH	3,199	YEAR 95	3. TIME OF DEATH 8:40 A M		
	4. SOCIAL SECURITY NUMBER 215-24-0531	1 □ M 2 🏋 F 67		IF UNDER 1 YEAR	IF UNDER 24 HRS. HOURS MIN.	7. DATE (Mont	OF BIRTH th, Day, Ybar) . 6, 192		8. BIRTH Countr	IPLACE (State or Foreign		
POR	A STATE OF THE PARTY OF THE PAR	reet and number) FIELD AVENUE			IMORE	DEATH		9c. COUN BAI		DRE CITY		
DIRECTOR	PRESIDENCE OF DECEDENT 10a. STATE MARYLAND B	ALTIMORE CIT		TOWN OR LOCA	BALTIMO	RE		10d. INSIDE CITY LIMITS? 1 🔯 YES 2 🗌 NO				
FUNERAL	100. STREET AND NUMBER 582 S. BEECHFIELD	AVENUE		10	ZIP CODE	1229			ZEN OF V	VHAT COUNTRY?		
В	11. MARITAL STATUS 1 Never Married 2 Merried 3 Widowed 4 X Divorced	12. WAS DECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR DA	2 NO	If yes, sp	ENDENT OF HISPA ecity Cuban, Mexico 2 XNO Speci	en, Puerto	4? (Specify Yes Rican, etc.)		14. RACE	- American Indian, t, White, etc.		
COMPLETED	15. DECEDENT'S EDUC (Specify only highest grade of Elementary/Secondary (0-12) H/S GRAD	ATION completed) College (1-4 or 5+)	16a. DECEDENT'S UT (Give kind of wo life. Do NOT use TELEPHON	rk done during mo retired.)	st of working		KIND OF BUS			PHONE SERVICE		
BE COM	17. FATHER'S NAME (First, Middle, Last) EARL CROSS				18. MOTHER'S NA		Middle, Meiden			HONE BERVIO		
5	MRS. PATRICIA BLA	IR			nd Number or Rural ER ROAD					21229		
	20a. METHOD OF DISPOSITION 1 Surfel 2 Cremetion 3 Remo 4 Donation 5 Other (Special State of State of Special State of Special	val from State Cem	PLACE AND DATE OF elery, crematory or othe ADOWRIDGE	LAGE AND DATE OF DISPOSITION (Name of DATE 20C. LOCATION — City or Town, Stata DOWRIDGE MEMORIAL PARK 12/16 ELKRIDGE								
	· Thues	cek	lus	HUBBAR 4107 W	D FUNERA ILKENS A	L HOI	E-BALT	IMORE		21229		
	23. PART I. Enter-the diseases, or conshock, or heart failure. L. IMMEDIATE CAUSE (Final disease or condition resulting in death)	Lang	CONSEQUENCE OF:	t enter the mo	de of dying, suc	ch as care	dec or respl	ratory arre	est,	Approximate Interval Between Oneet and Death		
ERTIFICATION	Sequentially list conditions, if amy, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):											
MEDICAL C	PART II. Other significant conditions	contributing to deeth bu	it not resulting in	the underlying	n Part I. 24s. WAS AN AUTOPSY PERFORMED?			24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATHY				
SICIAN: M	DID TOBACCO USE CONTR		F DEATH YES		UNCERTAIL	N 🗆				1 YES 2 NO		
HYSIC	EXAMINER? 1 YES 2 YOU 27. MANNER OF DEATH	HOSPITAL: 1 Inpatient 2 ER/Output 28e. DATE OF INJURY			8 5 Residence							
87 1	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	INJUF	M 1 1	ES 2 NO		SCRIBE HOW IN					
EIEU	4 Homicide detarmined	Momicide detarmined City or lown, State)										
COMPLE		IAN: To the best of my knowle On the basis of examination								and manner as stated.		
O BE C	296. SIGNATURE AND TITLE OF CERTIFIER 30. WAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF DEA	TH (ITEM 27) /Time P	rint)	29d. DATE SIGNED (1) 1				(Month, Day, Year) $3-95$			
	DR. YUDHISHTRA MA	RKAN - 1406-	B CRAIN	*	- SUITE	202	-GLEN	BURNI	E, N	MD 21061		
	31. DATE FILED (Month, Day, Year) DFC1 8 1995	32. REGISTRAR'S SIQUE	TUBE									

DHMH-16 Rev 1/89

X 6876 BALTIMORE, MARYLAND 21215-00	TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed wirdin 24 hours after death. Page 6 may be retained by the hospital or attending pl	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the by be filled within 72 hours after death with the State Dept. of Health and Memtal Hygiene prior to burial, cremation, or removal.	umatic event, the medical examiner must be notified at once.
DIVISION OF VITAL RECORDS, P.O. BOX 6876	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the 1 be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal,	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

29b. SIGNATURE AND TITLE OF CERTIFIER

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

ITEM: 2. PER	UNCDITA	ETIM C	21 1/10	1/06 + 3	L					9	5 3	8133
FOR	HUSFITA	STATE OF M				T OF H	FALTH AND	MENT	AL HYGIENI	F		
- STATE REGISTRAR							DEATH	***************************************	REG. NO.	•		
1. DECEOENT'S NAME (First,	0 - 0	0	11	200	0.	n 1			TE OF DEATH	v 13	YEAR 3.	TIME OF DEATH
KO	GER	SD	+10	JKG	11	4			cember	#1	995	19155P"
4. SOCIAL SECURITY NUMBER			B. AGE (In yrs.		IF UNDER	DAYS	IF UNDER 24 HRS		TE OF BIRTH onth, Day, Year)		6. BIRTHPLA Country)	ACE (State or Foreign
224-60-6152		1 🔀 M 2 🗆 F	80	YRS.					T.9,191			n,Mass.
9a. FACILITY NAME (If not ins					9b. CITY		OR LOCATION OF	DEATH			TY OF DEAT	
ST. AGNES H		<u> </u>				BAL	TIMORE			BAL	TIMOR	E CITY
10a. STATE	10b. COUNTY			10c. CIT	Y, TOWN	OR LOCAT	ION				10	d. INSIDE CITY
									LIMITS?			
10e. STREET AND NUMBER						101	. ZIP CODE			10g. CITI	ZEN OF WHA	T COUNTRY?
719 MAIDEN	CHOICE	LANE					21228				U.S.A	•
11. MARITAL STATUS		12. WAS DECEDENT FORCES? 1 [ENDENT OF HISI		GIN? (Specify Yea	or No-	14. RACE -	American Indian, hits, etc.
1 Never Married 2 1 1 3 V Widowed 4 Divor		IF YES, GIVE WA					2X NO Spe		to riceri, etc.)		Specify:	
Λ	DENT'S EDUCA	TION		DECEDENT'S								WHITE
(Specify only	highest grade co	empleted)		(Give kind of life, Do NOT u	work done	durina mo			16b. KIND OF BUS	IINESS/INO	USTRY	
Elementary/Secondary (0-		College (1-4 or 5+) 4 YRS					E OFFIC	FR	U.S. G	WERN	MENT	
17. FATHER'S NAME (First, Mil		7 110	110	TEL CIT	U DE	KV LO			st, Middle, Maiden		IIIIIII	
HENRY V. HO	RGAN						LUCY					
19a. INFORMANT'S NAME (Ty	pe/Print)			19b. MAILING	ADDRES	S (Street a	and Number or Rui	ral Floute N	umber, City or Town	n, State, Zip	Code)	
MR. ERNEST	GRAVES			2328	S. N	ASH S	STREET	- AR	LINGTON	, VA.	222	02
20s. METHOD OF DISPOSITION TO Burial 2X Cremetion		al from State		CEANDDATE				0	ATE 20c. LO	CATION -	City or Town,	State
4 Donstion 5 Other		ar nom state	HIL	LTOP	CREM	ATOR	Y	12	2/18 TO	OWSON	I	
21. SIGNATURE OF FUNERAL	SERVICE LICE	NSEP)	11				ND ADDRESS OF		HOME IN	7		
New	26	Donie	U_)					NUE-BAL'	-	E. MD	21229
23. PART I. Enter the di	sesses, or co	mplications that	caused the	death. Do								Approximats
ahock, or he IMMEDIATE CAUSE (Fin		et only one caus	e on each i	ins.								Interval Between Onset and Daath
disesse or condition		ASPIRA	TON P	NEUMOI	ATIA							2-3 Days
resulting in death)	a.		OR AS A CON									
	D.	CHRONI	RENA	L FAII	LURE							2 Months or longer
Sequantially list condition if any, leading to immediate	ilate	OUE TO (OR AS A CON	SEOUENCE C	OF):							2 Months
CAUSE (Disease or inju		BILATE				SIS						or longer
that initiated eventa resulting in desth) LAS		BLADDE	OR AS A CON		,	гттт	c					2 Months
	d.	DHUDDE	CALO	OLI &	GIS.	TTTT	5					or longer
PART II. Other algnifica	nt conditions	contributing to	leath but n	ot resulting	in the u	nderlyin	g cause given	in Part I				ERE AUTOPSY FINDINGS
		scleros							PERFOR		00	MPLETION DF CAUSE DEATH?
Carcinoma of arcetate aland									YES 2 NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO 🖫 UNCERTAIN 🗆												
25. WAS CASE REFERRED TO EXAMINER?		HOSBITAL	28. P	LACE OF DEA							****	
1 YES 2 XNO		HOSPITAL:	ER/Outpetien	3 🗆 DOA	4 Nu		ne 5 🗆 Residen	ce 6 🗆 C	Other (Specify)			
27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED												
	Pending investigation				М	1 🗆						
3 Suicide 8 Could not be detarmined 28e. PLACE OF INJURY — At home, farm, streat, factory, offica building, atc. (Specify) 28e. PLACE OF INJURY — At home, farm, streat, factory, offica building, atc. (Specify) 28f. LOCATION (Street and Number or Rural Route Number, City or Yown, State)											te Number,	
			-							7		
		AN: To the best of										
2 MEOI	CAL EXAMINER	On the besis of ax	amination and	/or investigati	lon, in my	opinion, d	death occured at	the time, o	data and place, an	d due to th	ne cause(a) a	nd menner as stated.

29c. LICENSE NUMBER

D04964

Dr. William J. Hicken St. Agnes Hospital 900 Caton Avenue Baltimore, MD 21229

The Contemporary

DHMH-16 Rev 1/89

29d. DATE SIGNEO (Month, Day, Year) December 14, 1995

DHMH-16 Rev 1/89

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FOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAR CERTIFICA	TE OF DEATH	REG. NO.									
	1. DECEDENT'S NAME (First, Middle, Last)		2. DATE OF DEATH	3. TIME OF DEATH								
	Shirlev J. Hyman		Dec. 14, 1995									
		NDER 1 YEAR IF UNDER 24 HRS.	7. DATE OF BIRTH	8. BIRTHPLACE (State or Foreign								
	250-34-3216 1 M 2 X F 71 YRS. MONT		(Month, Day, Year) June 25, 1924	S. Carolina								
	Se. FACILITY NAME (If not institution, give street and number) 9b.	CITY, TOWN OR LOCATION OF DE	ATH 9c. COL	UNTY OF DEATH								
DIRECTOR	235 Highlander Drive Glen Burnie Anne Arundel											
REC	10e. STATE 10b. COUNTY 10c. CITY, TO	WN OR LD CATION		10d. INSIDE CITY LIMITS?								
	Maryland Anne Arundel	Glen Burnie		1 TES 2 NO								
FUNERAL	10s. STREET AND NUMBER	101, ZIP CODE	10g. CI1	TIZEN OF WHAT COUNTRY?								
9	235 Highlander Drive	210	61 Uni	ted States								
5	11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ABMED FDRCES? 1 YES 2 NO	13. WAS DECENDENT DF HISPAN If yes, specify Cuben, Mexica	IIC ORIGIN? (Specify Yes or No-	14. RACE — American Indian, Black, White, etc.								
ВУ	1 Never Merried 2 Merried IF YES, GIVE WAR OR DATES 3 Widowed 4 Divorced	1 YES 2 NO Specify	r.	Specify:								
			1	white								
	15. DECEDENT'S EDUCATION 18e. DECEDENT'S USUI (Specify only highest grade completed) (Give kind of word) (if the Do NOT use reti	lone during most of working	16b. KIND OF BUSINESS/IN	IDUSTRY								
쁘	Elementary/Secondary (0-12) College (1-4 or 5+)	· •u.)										
ğ.	12 Mill Wor		Texti									
COMPLETED	17. FATHER'S NAME (First, Middle, Lest) Franklin Jordan	The same of the sa	ME (First, Middle, Maiden Sumame) rt.ha									
BE												
2	19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADD	RESS (Street end Number or Rural I	Route Number, City or Town, State, Z	ip Code)								
-			Glen Burnie. M									
	20a, METHDD OF DISPOSITION 1 Deniel 2 Cremation Commence Comments of the Comme	(ace)		- City or Town, State								
		Cem. Dec. 16,		n, MD								
	21. BIOMATURE OF PUMERAL SERVICE LICENSEE	22. NAME AND ADDRESS OF FA	ck Funeral Hom	10								
	Les Ma Posts	_		rnie. MD 21061								
ION	23. PART I. Enter the diseases, or complications that caused the death. Do not e ahock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate		0	Approximate Interval Batween Onset and Death 245 Smos. 54 ays								
CERTIFICATION	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated eventa resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): d											
DICAL	PART II. Other algnificant conditions contributing to death but not resulting in the	e underlying ceuse given in	Part I. 24a. WAS AN AUTOPSY PERFORMED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE								
ED			— 1 TES 2 XND	DF DEATH? 1 ☐ YES 2 (∑) NO								
: ME	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES	NO UNCERTAIL	<u>_</u>	To res 2 Mino								
AN	25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (C		Loud									
PHYSICIAN:	EXAMINER? HOSPITAL: OT	HER:	A (7 a) (8 a)									
178	27. MANNER OF DEATH 288. DATE OF INJURY 28b. TIME OF	Nursing Home 5 Recidence	6 Other (Specify) 28d, DESCRIBE HDW INJURY O	CCURED								
	1 Natural 5 Pending (Month, Day, Year) INJURY	WORK? M 1 YES 2 NO										
ВУ	2 Accident Investigation 3 Suitelds 26e. PLACE OF INJURY — At home, farm, street		261, LOCATION (Street and Numb	ner or Rural Route Number								
ED	3 Suicide 8 Could not be 4 Homicide determined	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	City or Town, State)									
Ē	290. CERTIFIER											
COMPLETED	(Check only CEHTIPTING PHYSICIAN: To the best of my knowledge, death occurred at			XX for an arrangement of the same								
Ö	2 MEDICAL EXAMINER: On the besis of examination end/or investigation, in	my opinion, death occured at the	Ilme, date and place, end due to	the ceuse(e) end menner es stated.								
ш	EMBANDINATURE AND TITLE OF CERTIFIER	290-LICENSE NU	WBER 29d. DA	ATE SIGNED (Month, Day, Year)								
0 8	I wood will know	103	331	Jecember 14,1915								
10	THE AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Prin	"Zrain Hich	Nov Rong	Decore 14-7/06/								
	31. DATE FILED (Month, Day, Year) 32. REGISTRAND SIGNATURE	11/2	17)	VICTO GOV								
	NECT & 1995 July Otwology Randally		*									

Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible.

State of Maryland / Department of Health and Mental Hygien 6 5 38 137

				,	Cert	ificate of	Death	Re	ig. No.	00	10	
Physici	ian	1. Decedent's Neme (First, Middle						2. Dete of Deet	h	Year.	3. Time o	
/Medic		WARWI		LIAM	HALI	BROOK		December	1		6:30	P.M.
Examir	rier	4a. Facility Neme (If not institution		r)			4b. City, Town, or Lo	ocation of Deeth	4c. County	of Deeth		
P 1		1230 Holmewood 5. Social Security Number		Age (In yrs. les	t hirthday)	If Undar 1 Yaa	Pasaden r If Under 24 Hrs.	8. Data of Birth	Anne	Arun		or Foreign
Funeral Director		066-09-0772 Usuel Rasidance of Decedent	1 M M 2□F	89		Months Deys		(Month, Day, Februar			Tex	or Foreign
yland how		10e. Stete 10b. County		10c. City,	Town or Loca	ition				10	Od. Inside C	
Sa-4 s	ctor		Arundel	Pa	sadena						1 🗆 Yes	s 2) No
P or 2	Dire	10e. Street and Number				10f. Zip Code		10	og. Citizen of \		try?	
math math	erai	1230 Holmewood	· ·	t Francis II C	12 144		L22	asit. Van an Na		S.A.	an Indian	
be filed within 72 pdgs after death with the Marylar fat Physiene. d other than "natural", or lisms 22s or 28s-f show event, the Medical Examiner must be notified at	by Funeral Director	11. Marital Stetus 1 □ Never Merried 2 □ Marri 3 □ Widowed 4 █ Divorced	12. Was Deceden Armed Forcas ied 1 Yes 2 fif Yes, Give Yaar or Datas	? ∫No		es, specify Cu Yes 2 No	Hispenic Origin? (Sp ban, Maxican, Puerto Specify:	Rican, etc.)	Bled	e - America ck, White, e Whi	etc.	
e filed within 72,36555 if Hygiene. other then "natural", vent, the Medical,Ext	Completed	15. Decedent (Specify only highas Elementery/Secondary (0-12)	t's Education of grade completed) College (1-4o)		16e. Deceder (Giva kir life. DC	nt's Usuai Occi nd of work don O NOT use retir	upation e <i>during</i> most of work ed)	ing	16b. Kind of B	usiness/Ind	ustry	
filed wit Hygiene ther the ent, the	Com	12	4	34)	Engin	eer			Lockhe	ed Ai	rcraf	t
E STOR	Be	17. Fether's Neme (First, Middle, L	Last)				18. Mother's Nem	a (First, Middle, N	feiden Sumen	ne)		
s 1 and 2 should Health and Men than 27 is marks other traumetic	7	William Hall			401 44 11			e Bryant				
and 2 sho ealth and 8 n 27 is ma		19e. fnforment's Neme/Reletionsh					et and Number or Rur					22
of Health I them 27 r other tr		Jackie Collins 20e. Method of Disposition			e of Disposit	ion (Neme of tory or other pl	wood Drive		20c. Location -			.22
Pages nent of int: If its ary or o		1 ☐ Buriel 2 M Cramation 4 ☐ Donetion 5 ☐ Other (Sp	3 ☐Removel from State pecify)	8		matory	1	13/95	Baltin	more.	Marv	land
permit. Pages 1 and 2 should by Department of Health and Menta important: If them 27 is marked any injury or other traumetic enonce.		21. Signature of Füheral Septe L	Consee				ress of Fecility Funeral Ho tain Road					
		23e. Part1, Enter the disease, or shook, or head failure. List of	complications that caus	ed the deeth.	Do not enter	J4 MOUN the mode of dy	ring, such as cardiac	Pasadi or respiretory erre	ena, Ma	arylar	Approxime	1122 eta
Physician		shook, or head failure. List o	U							į	Interval Be Onset and	J Deeth
/Medical Examiner		Immediate Cause (Final disaese or condition resulting in deeth)	e. CAR	INOM	4 81.	203 774	PEL VIS				MONT	775
	i i	resulting in Geotti)	L	Due to (or a	s a conseque	ence of):	2			1	MONT	
uted d ansit	Examiner		b. MEMS	MIX	70 63	ONE +	REC VIS			1	Hear	15-
an an												
cate be executed physician and s the burial-transit	edicai	that initiated events rasulting in deeth) Last Dua to (or as a consequence of):										
5 0 6	Physician/Med	d								1		
death	sicia	Pert fi. Other significant condition	ns contributing to death	but not resulti	ng in the und	erlying cause g	iven in Pert I.	23b. Did to	bacco usa co	ntributs to	the cause	of death?
v requires that the death cer been signed by the attendin should be detached for use	Phy	HYPER TENSI	TOW +	ATI	15005	CLERO	525	1 □ Ye	18 20 No	3 Prob	ebly 4	Unknown
signe Id be	d by	1.		, , ,				24a. Wes er	autonev	24b. Wa	ra sutopsv	findings
e law requ has been ge 2 shou	Completed	MULTS - FN)						perform		eva	Illable prior npietion of death?	to
Physician: The la this certificata has tral director, page 2	S	Norvey C fra	55 Mg //	PROC	80140	us		1□ Ye	s 2 No	10	Yes 2,2	No
fclan certifi rector	o Be	25. Wes case referred to medical examiner?	Hospitai			0	28. Place of Deet		-4			
Phys r this aral di		1 Yes 2 No	28a. Date of in	tient 2 EF	NOutpatient Bb. Time of	3LI DUA	4 LI Nursing Ho	me 5 Reside 28d. Describe ho)	
ath. :: Afte a fund	ation	1 Neturel 5 Pending 2 Accident investige	g (Month, D	ey Year)	injury	28c. fnj W	ork?] Yes 2 No		,,			
r Atte tar de irector n by th	Certification:	3 ☐ Sulcida 6 ☐ Could no 4 ☐ Homicide datermin	inad 288. Piece of it	njury - At home	e, ferm, stree	t, factory, office	• 0	28f. Location (Str City or Town	eet end Numb , State)	er or Rurai	Route Nur	mber,
oltal o		00.0.11										
To the Hospital or Attending Physician: within 24 hours after deals. To the Funeral Director: After this certification in the funeral director, completely filled in by the funeral director,	edical	29e. Certifier Certifying (Check only one)	g Physician: To the best Examinar: On the basis and menner s	of examinetior	edge, death o	ccurred et the t stigetlon, in my	time, dete end plece, opinion, deeth occuri	end due to the ca ed at the time, de	use(s) end me ite end place,	anner as sto and due to	ated. the cause((s)
with To t	Σ	29b. Signature and title of certifier				1000	se number	29	d. Date signe	d (Month, L	Day, Year)	
10		1020	De	H.L	0,	019		1	2/12/	195		
L		30. Neme end eddress of person w	4 4		3a) (Type, Pri	int)	AMC DA	6.	Russ	De I	1,2	106/
Sta	te	DN PO 14057 / 31. Date filed (Month, Day, Year)		T SOU	20	0/108	+17C 013	the CXSO	- Bues	22/	MARY	die
Registr.		DEC 1 8 1995	32. Regist	Kardall								

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Baltimore, Maryland 21215-002

Division of Vital Records, P.O. Box 68760,

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DIVISION OF VITAL RECORDS, P.O. BOX 68760	radigine
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2	NING
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	HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be secured within 28

	1 - STATE REGISTRAR 1. DECEDENT'S NAME (First, Middle, Last)	STATE OF N		D / DEPAR CERTIF						REG. NO			3. TIME OF DEATN	
	JOSEPHINE 4. SOCIAL SECURITY NUMBER	5. SEX		IACO						0 18°	1990	YEAR	3:20 pm	
TOR	218-14-0664 9a. FACILITY NAME (If not institution, give	1 M 2 XF	9 1	s. last birthday) YRS.	MONTHS 9b. CIT		DAYS HOURS MIN. 3-9-1904 OWN OR LOCATION OF DEATH 9c. CO				9c. COUNT	e. BIRTHPLACE (State or Foreign Country) I taly DUNTY OF DEATN 3 altimore		
CTOR	Saint Joseph Med	ical Center				IOWS	on, r	Varyla	and		Dai	umor		
DIRE	Maryland 10b. count	N.A.		10c. CIT	Y, TOWN	Baltimore						IOd. INSIDE CITY LIMITS? VES 2 NO		
FUNERAL	5009 Frankford				10f. ZIP CODE 21206						τ	J.S.	A .	
6	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT FORCES? 1 IF YES, GIVE W	YES 2	₩ NO	13.	If yes, sp	ecify Cubi		IC ORIGIN? (n, Puerto Ric		or No- 1	Bleck,	American Indian, white, etc. White	
PLETED	15. DECEDENT'S EDI (Specify only highest grad Elementary/Secondary (0-12) 6 th	College (1-4 or 5 +		Give kind of the Do NOT use	vork done se reu ad.)	during mo	st of worki	ng	16b. K		n hor			
at once.	17. FATHER'S NAME (First, Middle, Last)	N.A.					18. MOT	NER'S NAI	ME (First, Mid	dle, Maiden	Surname)			
o BE	Michael 19a. INFORMANT'S NAME (Type/Print)	Cive	tta	19b. MAJLIN	ADDRES	S (Street e	nd Numbe	<u>fari</u>	anna	Chi or Tour	oskes	S Cordel		
	Mary Palmer	Do	ve	Cre	ek V	Vay S	parl	cs, M	id.	ot. 203 21152				
must be	20a. METHOD OF DISPOSITION 1 St Burlat 2 Cremation 3 Ramoval from State 4 Donation 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of cemptery, crematory or other place) HOLY Redeemer Cemetery 12-19Balto. M										ty or Tow	ryland		
on, or removal.	21. SIGNATURE OF FUNERAL SERVICE L	CENSEE	vne	10	22.	NAME AN	ID ADDRE	SS OF FAC	YTLIK				al Home Md.2122	
i Hygiene prior to burial, cremati, or other traumatic event, ti	disease or condition resulting in death) Due to (or as a consequence of): Sequentisity list conditions, if smy, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that Initiated events resulting in deeth) LAST Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):										12 HRS			
pt. of Health and Mental 3 shows any Injury, o N: MEDICAL CE	PART II. Other significent conditions contributing to death but not resulting in the underlying CONGESTIVE HEART FAILURE OGLIVE SYNDROME							F			e. WAS AN AUTOPSY PERFORMED?		4b. WERE AUTOPSY FINDINGS MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATN? 1 YES 2 NO	
Dept. o	DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL	RIBUTE TO CAI		PLACE OF DEAT			(UNC	ERTAIN	1 🗆					
the State Dept 1, or Item 23 HYSICIAN	EXAMINER?	HOSPITAL:		T	OTHE	R:	• 5 □ R	sidence	6 Other (S	(pecify)				
The Part of	27. MANNER OF DEATN 1 Naturel 5 Pending 2 Accident Investigation	28a. DATE OF (Month, Da		28b. TIM INJ	E OF URY M		URY AT RK? 'ES 2] NO	28d. DESCR	IBE HOW II	YJURY OCCU	RED		
ED is	3 Suicide 8 Could not be 4 Homicide determined	28a. PLACE Of building,	FINJURY — A etc. (Specify)	At home, farm, s	treet, fac	tory, office				ON (Street a fown, State)	and Number or	Rural Ro	rte Number,	
2 = 3	29e. CERTIFIER (Check only one) 1 CERTIFYING PNYS	ER: On the basis of ax											ind menner ea stated	
be filed within IMPORTANT: TO BE COI	296. SIGNATURE AND TITLE OF CERTIFIE	RO					_	ENSE NUM 46673	- 1		29d. DATE 5	_ /	fonth, Day, Year)	
F	30. NAME AND ADDRESS OF PERSON WI	RINO M.D.,	7620	YORK		TOW	SON	, MA	RYLAN	0 212	04			
	DEC 1 8 1995	31 REGISTRA	S SCHOOL S	ţ.										
,													DHMH-16 Rev	



		1 - STATE REGISTRAR	STATE OF MA				HEALTH AND	MENTAL HYG				
	i i	1. DECEDENT'S NAME (First, Middle, Last) WILLIAM L. JOHNS						2. DATE OF DEAT MONTH	Н	YEAR	TIME OF DEATH 8:00 A	
P		4. SOCIAL SECURITY NUMBER 219-10-6285	5. SEX 6.	AGE (in yrs. in	yrs.	IF UNDER 1 YEA		7. DATE OF BIRTI (Morith, Day, Vo.	d a		ACE (State or Foreign	
2, 3 should	OR	•a. FACILITY NAME (If not institution, give CHESAPEAKE MANOR		ME		9b. CITY, TOW ARNO	ON OR LOCATION OF D		ANNE	Y OF DEAT	Н	
Pages 1,	DIRECTOR	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNT MARYLAND ANNE	ARUNDEL			y, town or lo				10	d. INSIDE CITY LIMITS?	
sit permit.	FUNERAL (100. STREET AND NUMBER 212 JUMPERS HOLE			THEFT	JEKSVII	101. ZIP CODE 21108				T COUNTRY?	
21215-0020 I or anoming physician. For use at the burial-transit	BY FUN	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT E FORCES? 1 I IF YES, GIVE WAR	YES 2	RMED NO	If yes	DECENDENT OF HISPA , specify Cuben, Mexic YES 2X NO Speci	an, Puerto Rican, etc	USA y Yes or No — 14	Specify:	American Indian, filte, etc.	
	COMPLETED	15. DECEDENT'S EDI (Specify only highest grad Elementary/Secondary (0-12)	UCATION le completed) College (1-4 or 5+)	III	Bive kind of u	se retired.)	ATION most of working	16b. KIND OI	16b. KIND OF BUSINESS/INDUSTRY			
	SOMP	12 17. FATHER'S NAME (First, Middle, Last)		TR	UCK I	DRIVER	16. MOTHER'S N.	ANNE AME (First, Middle, Me	ARUNDEL aiden Surname)	. CO.		_
MARYL retained 5 should be notified at	BE	UNKNOWN 19a. INFORMANT'S NAME (Type/Print)		15	Db. MAJLING	ADDRESS (Stre	UNKNOW net and Number or Rural		Town State Zio Co	nde)		_
m g g a	5	JOANNA NIGHTINGA	LE	9	73 LC	ONGVIEW	AVE. PAS	ADENA, M	D 21122			
O H e 6 m ector.		1 Donation 5 Other		cemetery, cri	ematory or o	of disposition ther place) IATORY,		12/18 B	aLTIMORE			
death.		21. SIGNATURE OF FUNERAL/SERVICE L	61		_	426	OND C. FI CRAIN HWY	SW GLEN	BURNIE,		1061	
Co. BOX 68760 Box 68760 Certificate be executed within 24 hours after ding physician and completely filled in by the hygiene prior to burial, cremation, or removal other traumatic event, the medical	RTIFICATION	23. PART I. Enter the diseases, or shock, or heart feliure immediate CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events	a. Due to (or Due to (or C.	on each lin	QUENCE OF	Has	ort F	•		t,	Approximata interval Batweer Onset and Death / Wesk	h
다 등 등 그 이	CERTI	resulting in death) LAST	d								ļ	
RECORD: requires that the een signed by the of Health and M shows any inju	I: MEDICAL	PART II 9ther significant condition OF CHAPTER DID TOBACCO USE CONT	n g	tu	- 1	108le	li	1 D YE	S AN AUTOPSY REORMED?	CO OF	ERE AUTOPSY FINDINGS AILABLE PRIOR TO IMPLETION OF CAUSE DEATH? YES 2 NO	
TAL The lar ate has ate Deg	PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLA	CE OF DEAT	TH (Check only o	ne)					_
PHYSICIAL this certifi with the	ву РНУ	27. MANNER OF DEATH 1 Derdrel 5 Pending	1 Inpatient 2 EF 28a. DATE OF INJ (Month, Day, 1)	URY	28b. TIM	E OF 28c.	INJURY AT WORK? YES 2 NO		OW INJURY OCCU	AED (33)		
TOR: A after de 28 is	ETED B	2 Accident Investigation 3 Suicide 8 Could not be 4 Homicide detarmined	28s. PLACE OF IN building, etc.	JURY — At he (Specify)	ome, farm, s	Rireet, factory, o	ffice	281. LOCATION (Street and Number or Rural Route Number, City or Town, State)				
절보었는	COMPLE		SICIAN: To the best of my ER: On the besis of exam								d manner as stated.	
TO THE HOSPI TO THE FUNER be filed within	H	29h GIGNATURIPAND TITLE OF CERTIFIE	y Alter	.du	PD	octer	29c. LICENSE NU	MBER 1684	29d. DATE 9	IGNED (Mo	onth, Day, Year) 8,95	
	70	30. NAME AND ADDRESS OF PERSON WI	M.D	1600	M 27) (Typo.	Print) AIN	6w7,	GLEN	BURNIE	21	.06/1	
		DEC 1 8 1995	32. REGISTRAR'S	SIGNATURE								

BALTIMORE, MARYLAND 21275-0020	4 hours after death. Page 6 may be retained by the hospital br, attending physi	filled in by the funeral director, page 5 should be detached for use as the buria m, or removal.	re medical examiner must be notified at once.
DIVISION OF VITAL RECORDS, P.O. BOX 6876	THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 74 hours after death. Page 6 may be retained by the hospital be, attending bithysicial	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-to filled within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DEC 1 8 1995

	1 - FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.) 40										
OR	REVELL ALEXANDER JEETER DECEMBER 11, 1905 3 4. SOCIAL SECURITY NUMBER 212 09 2116 1 M 2 F 87 VRS. S. AGE (In yrs. lest birthdey) MONTHE DAY HOURE 24 HRS. 1. DATE OF BIRTH (Month, Dey, Year) MONTHE DAY NO. TO ATE OF BIRTH (Month, Dey, Year) MARCH 9, 1908 MARYLAI 9a. FACILITY NAME (If not institution, give street and number) NORTH ARUNDEL HOSPITAL GLEN BURNIE ANNE AF	_										
FUNERAL DIRECTOR	Maryland Anne Arundel Pasadena 1 1 Y 100. STREET AND NUMBER 8095 Round Table Court 21122 U.S.A.											
ВҰ	15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY	ite										
COMPLETED	(Specify only highest grade completed) Elementary/Secondary (0-12) 12th 17. FATHER'S NAME (First, Middle, Last) (Give kind of work done during most of working life. Do NOT use retired.) Painter 18. MOTHER'S NAME (First, Middle, Maiden Surmame)	ydock ders &										
TO BE C	Rubin Jeeter Nannie Jordan 19a. INFORMANT'S NAME (Type/Print) Jeanette Endley Rubin Jeeter Nannie Jordan 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8071 Escalon Avenue Pasadena, Maryland	21122										
	20a. METHOD OF DISPOSITION 1 X Burlel 2 Cremetton 3 Removal from Stata 4 Donatton 6 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, cremetery, cremetery, cremetery, cremetery) 20c. LOCATION — City or Town, State Cedar Hill Cemetery 12/15 Baltimore, Man											
NO	George J. Gonce Funeral Home P.A. 4001 Ritchie Hwy. Baltimore, Md. 21225 23. PAD. Enter the diseases of complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Finel disease or condition resulting in death) Due to (or as a conscouence of): BALTERE WA											
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):											
MEDICAL	PART II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. DIABETE NELL TUS ATTEM FISCI LLATION 1 YES 2 MO 1											
Y PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 26. PLACE OF DEATH (Check only one) OTHER: 4 Nursing Home 5 Rasidence 6 Other (Specify) 27. MANNER OF DEATH Netural 5 Pending Investigation Netural 5 Pending Investigation											
APLETED BY	3 Suicide 6 Could not be determined 26a. PLACE OF INJURY — At home, tarm, street, factory, office 4 Homicide 26a. PLACE OF INJURY — At home, tarm, street, factory, office City or Town, State) 26b. LOCATION (Street and Number or Rural Route Number of Rural Route											
TO BE COMPL	2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and placa, and due to the cause(a) and my opinion. Signature and Title de-Gertifier 29b. SIGNATURE AND TITLE DE-GERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, DATE) 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)											

COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

2. REGISTRADE SIGNATURE DHMH-16 Rav 1/89

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BALTIMORE, MARYLAND 21215-0020

	FilmG, 730, ite: FOR 1-REGISTRAR	m #11,19b STATE OF M	ARYLAND /	DEPAR	cyw, per TMENT OF H ICATE OF	IEALTH AND I	MENTAL HYGI			
	1. DECEDENT'S NAME (First, Middle, Last)	5	- 01	- A	ONE		REG. 2. DATE OF DEATH MONTH	DAY	YEAR 3. TIME OF DEATH	
	4. SOCIAL SECURITY NUMBER 214-26-8512 9s. FACILITY NAME (Il not institution, give si	1 M 2 TE	8. AGE (In yrs. les	t birthday) YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Morth, Day, Yea 9-20-0		BIRTHPLACE (State or Foreign Country)	
DIRECTOR	Manor Care Nu	rsing Ce	enter		Ruxt			Baltimore		
	Md Ball	timore			Raltimo			10g, CITIZE	10d. INSIDE CITY LIMITS? 1 YES 2 NO EN OF WHAT COUNTRY?	
BY FUNERAL	7602 Clays Land 11. MARITAL STATUS 1 Never Merried 2 Married 3 Widdowed 4 Divorced	12. WAS DECEDENT FORCES? 1 [IF YES, GIVE WA	EVER IN U.S. AR	MED	13. WAS DEC		O 7 IIC ORIGIN? (Specify n, Puerto Rican, etc.	Yes or No.— 1	4. RACE — American Indian, Black, White, etc. Specity:	
COMPLETED	15. DECEDENT'S EDUC (Specify only highest grade Elementary/Secondary (0-12)	CATION completed) College (1-4 or 5+)	(Gi		USUAL OCCUPATION or done during mode retired.)		1.4-4.5.408	BUSINESS/INDU		
	Grade 11 17. FATHER'S NAME (First, Middle, Last) Lorman La	aird		Nur	'se	CANADA PARAGO	Nui ME (First, Middle, Mai na F'end		Home	
TO BE	190. INFORMANT'S NAME (Type/Print) Charlotte L. (1.4	7602	Clays	ond Number or Aurel F Glade Ro Lia Ba	Pour Number, City or D. Phoen	Fores Chata 7/a C	207 207	
	20a METHOD OF DISPOSITION 1 2 Burlal 2 Cremation 3 Remote 4 Donation 6 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICE		cemetery, cre-	matory or of	Pk.Ce		12-15-9		odlawn, Md.	
	G. Friman S	Schwah	onused the de	eth Do "	Ralt:	imore	nore Na Ma. 212	220		
	shock, or heart fellure. I	s. A	e on each line	5	Trok.		h aa cerdiac or re	apiratory arrea	Approximate interval Between Onset and Death	
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury	b	DR AS A CONSEC							
CERTIFI	that initiated events resulting in death) LAST	DUE TO (C	OR AS A CONSEC	DUENCE OF	7.					
MEDICAL	PART II. Other algoliticant condition	s contributing to d	leath but not n	eaulting i	n the underlying	g cause given in	PER	AN AUTOPSY ORMED? 2 DANO	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?	
PHYSICIAN: M	DID TOBACCO USE CONTR 25. WAS CASE REFERRED TO MEDICAL EXAMINER?	RIBUTE TO CAU			H (Check only one)	UNCERTAIN	10		1 Tes 2 No	
BY PHYSI	1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending Investigation	26b. TIMI	E OF 28c. INJ	e 5 Residenca URY AT RK? /ES 2 NO		ner (Specify) ESCRIBE HOW INJURY OCCUREO				
	3 Suicide 6 Could not be 4 Homicide detarmined	building, at	c. (Specify)		treet, factory, office		City or Town, St	ite)	Rural Route Number,	
COMPLETED	29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINES 29b. SIGNATURE AND TITLE OF CERTIFIER	R: On the basis of axa				eath occured at the	lime, data and placa		cause(s) and manner as stated.	
TO BE	30. NAME AND ADDRESS OF PERSON WHO	di m	OF DEATH (ITEM	1 27) (Type	Print)	29c. LICENSE NUM	2849	29d. DATE 5	1964 (Month, Day, Year) 2-14-95 Md.21204	
	AH GHILA	D1.MI	76	00	0560	ERZ	r. Ton	Son,	Md. 21204	

32. REGISTRAR'S SIGNATURE RANGEL



31. DATE FILED (Month, Day, Year)
DEC 18

Dr. Touson, Md. 212

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TENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	OR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the buriat-transit permit. Pages 1, 2, 3 should file death with the State Deat, of Health and Mental Hydien prior to buriat, command or memoral	PORTANT If them 28 is marked as item 23 shows any injury as other trainments as asset the marked as a marked as
ENDING PHYSICIAL	JR: After this certifiter death with the	le marked or
THE HOSPITAL OR ATTENDING PHY	D THE FUNERAL OIRECTOR: After this filed within 72 hours after death with	T if item 25
O THE HOS	THE FUNI	MPORTAN

													95	38	142	
	1 . S	OR TATE EGISTRAR		STATE OF N	MARYLAND C	/ DEPAR	RTMENT	OF H	EALTH DE AT	AND I	MENTAL	HYGIEN				
	1. DEC	EDENT'S NAME (First,	, Middle, Last)									OF DEATH		3.	TIME OF DEATH	
		CECILIA KEBER De									Dec	ember		1995	9:27 A M	
		CIAL SECURITY NUMB		5. SEX	6. AGE (In yrs. Is		IF UNDER	1 YEAR	IF UNDER	24 HRS.	7. DATE (OF BIRTH	ACE (State or Foreign			
	1	<u>6-03-4849</u>										14/1905 Maryland				
æ	9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCA									ON OF DE	EATH			NTY OF DEAT		
15	RESI	IVERVIEW			ES	sex				Ba	altim	ore				
DIRECTOR	10e. STATE 10b. COUNTY 10c. CITY, TOWN OR								ION					10	d. INSIDE CITY	
	Maryland Baltimore Essex										1	YES 2 KNO				
FUNERAL	1	TREET AND NUMBER		(a d. l.					ZIP CODE				10g. CITI		T COUNTRY?	
N N		"B" Fen	way N	12. WAS DECEDEN	T 51/50 101 11 0 11		1		2122					U.S.		
	16	lever Married 2	Merried		YES 2 X			If yes, spe	cify Cuba	n, Mexica	en, Puerto R	? (Specify Yes lican, etc.)	or No-	Black, V	American Indian, /hite, stc.	
B	3 X) W	Vidowed 4 Divo	rced	IF TES, GIVE W	AR OR DATES			I L YES	2 X NO	Specifi	y:				Specify: White	
OMPLETED			EDENT'S EDU		(0	ECEDENT'S Give kind of	work done			ng .	16b.	KIND OF BUS	INESS/INC			
빌	Elei	mentary/Secondary (0	1-12)	College (1-4 or 5 a	1/4	e. Do NOT u	ee retired.)					Ban	1-			
OM G	17. FAT	HER'S NAME (First, Mi	iddle Last)			56	scre	Lai		IEDIO MA	ANE (5)					
E S		anislau			16. MOTHER'S NAME (Flist, Mic					· · · · · · · · · · · · · · · · · · ·						
Med a		FORMANT'S NAME (7)			19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State.							n. Stein. Zin	Code)			
TO BE COM	Raymond S. Wheeler 2100 Flintshire Rd. Apt.202 Balt.MD.21237											21237				
	20a. METHOD OF DISPOSITION 20b, PLACE AND DATE OF DISPOSITION (Name of DATE 28c. LOCATION — City of Town State															
Ē	4 Donation 5 Other (Specify) Holy Rosary Cemetery 12/16/1995 Baltimore, MD.															
examiner must	21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Bruzdzinski Funeral Home P.A.															
	1407 Old Eastern Ave. Balt., MD.212											D.21221				
medica	23. PA	ART I. Enter the di	seeses, or c	complications the	ceused the de	eeth. Do i	not enter	the mod	de of dyi	ng, suc	h ee card	lac or respin	retory sm	eet,	Approximete	
E		DIATE CAUSE (Fin		Λ.	30 011 Cagit 1 1	-	\bigcirc		ι Λ			, ,			Interval Between Onset and Death	
Ę.		se or condition ing in deeth)	→	· Arterio Scleestie Coronau Univola Dureau							-	413				
event,	DUE TO (OR AS A CONSEQUENCE OF):															
er other traumatic		Sequentially list conditions, if any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF):														
S E	ceuse	Enter UNDERLYII E (Disease or Injui	NG	C]	
TIFIC	that in	nitiated events		DUE TO	OR AS A CONSE	OUENCE OF	F):									
	Tesuiti	ing in death) LAST		d												
AL C	PART	II. Other algnificat	nt condition	e contributing to	death but not	resulting	in the un	derlying	cause g	lven in	Part 1.	24a, WAS AN		24b. WE	RE AUTOPSY FINDINGS	
		urnic ole	utroct	ies (M)0	May '	(g 25	ore	_				PERFOR		CO	AILABLE PRIOR TO MPLETION OF CAUSE	
: ME	#	epo Typo	rd t	types 1)arath	pou	d				_		1		DEATH?	
N.:	DIÈ	TOBACCO US	SE CONTI	RIBUTE TO CA	USE OF DEA	ATH YE	S 🗆 1	10. 🗆	UNC	ERTAIN	VIDA					
SICIA	EX/	CASE REFERRED TO	MEDICAL	HOSPITAL:	26. PLA	CE OF DEAT	OTHER	-								
PHYSICIAN: MEDICAL		YES 2 NO		1 Inpatient 2		-	4 1 10		5 🗆 Res	sidence	6 Other					
			Pending	26e. DATE OF (Month, De		26b. TIM	E OF URY	28c, INJU WOR	HC?	,	28d. DE\$0	CRIBE HOW IN	JURY OCC	CURED		
		Bulalda	nvestigation	26e. PLACE OF	FINJURY — At he	ome, farm, s	street, facto		ES 2	NO	28/ LOCA	TION (Street as	nd Number	or Burn! Doug	Alumbar .	
TED		0 0	Could not be letermined	building,	etc. (Specify)			,			City o	r Town, State)	TO TYDINDE	or norm noun	Number,	
COMPLETED	290. CE	RTIFIER 1 DERTI	IFYING PHYSI	CIAN: To the best of	my knowledge, de	eth occum	d at the ti	me, date a	and place	and due	to the cour	sala) and men	ner en ekst	d		
W O	one			R: On the basis of ex											d menner as stated.	
_	290.310	SNATURE AND TITLE				-		_	29c. LICE					SIGNED (Mo	with, Dev. War)	
	14	reace /	June	Owner					DI	961	67		>	10 b	119/61	
2	30. NAM	E AND ADDRESS OF	PERSON WHO	COMPLETED CAUS	E OF DEATH (ITE	M 27) (Type,	Print)									

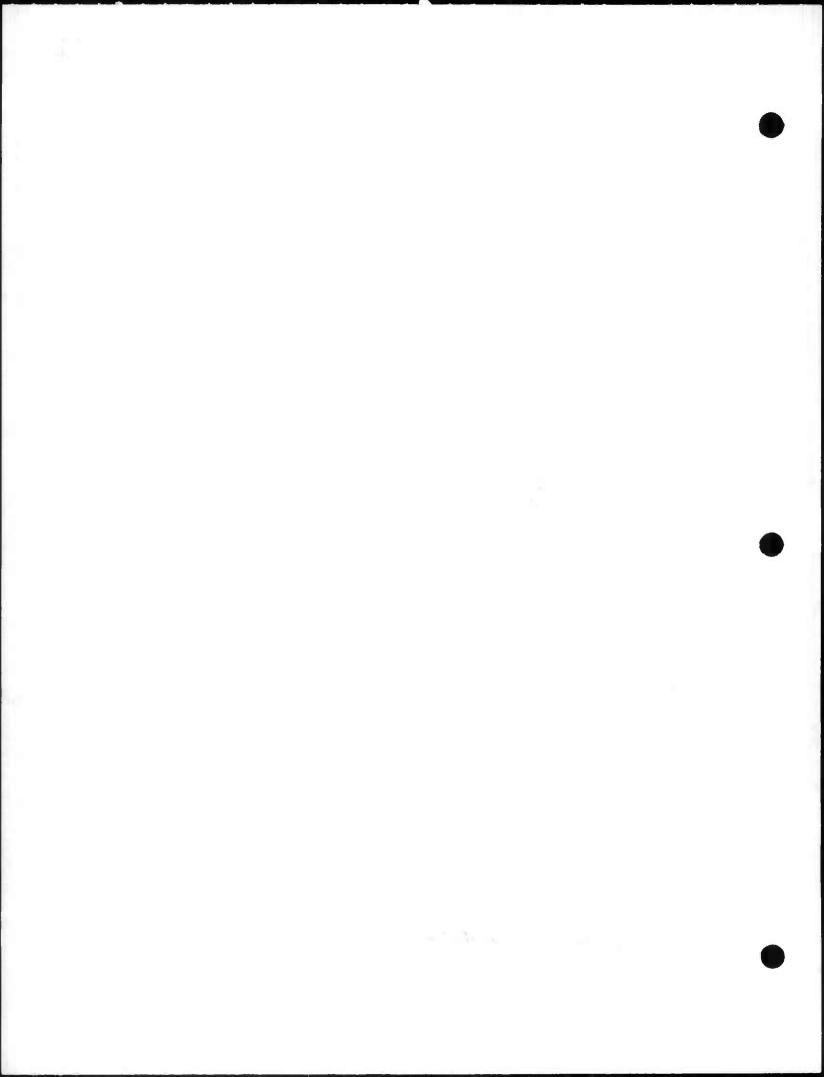
DR. MICHAEL SCHWARTZ 606 HAMMONDS LANE BALTIMORE, MARYLAND

11. DATE FILED (Monith, Day, Year)

DEC 1 8 1995

Jan. 324 BEGISTRAR'S CHAPTER

DEC 1 8 1995



3. TIME OF DEATH

1 YES P NO

a

4:15

8. BIRTHPLACE (State or Foreign

Virginia

14. RACE — American Indian, Black, White, atc.

Spec#White

22123

Approximata Interval Between Onset and Death

Minny

24b. WERE AUTOPSY FINDINGS

AMILABLE PRIOR TO

1 YES 2 NO

COMPLETION OF CAUSE

Sc. CONNITY OF DEATH

Charles

10g. CITIZEN OF WHAT COUNTRY?

U.S.A.

2. DATE OF DEATH

December 8,1995

FOR STATE REGISTRAR

t. DECEDENT'S NAME (First, Middle, Last)

Lee

5 SEX

Jackie

4. SOCIAL SECURITY NUMBER

7. DATE OF BIRTH Jan. 15, 1937 228-40-9214 DAYS HOURS 1 XM 2 F 58 Pages 1, 2, 3 should 9e. FACILITY NAME (If not institution, give street and number) SH CITY TOWN OR LOCATION OF DEATH DIRECTOR Physicians Memorial Hospital La Plata RESIDENCE OF DECEDENT 10c CITY TOWN OR LOCATION 10a STATE 10b. COUNTY Maryland | Prince George Waldorf permit. 10s. STREET AND NUMBER FUNERAL 10f. ZIP CODE 109 Brookside Place 20601 burial-transit hours after death. Page 6 may be retained by the hospital or attending physician. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Year or No-If yes, specify Cuben, Mexicen, Puerto Rican, etc.)

1 YES 2 NO Specify: t 🗌 Never Married 2 🔲 Merried ВY 3 Widowed 4 Divorced use as the Korea ETED tea. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use relired.) 15. DECEDENT'S EDUCATION pecify only highest grade complete t6b. KIND OF BUSINESS/INDUSTRY (Spe funeral director, page 5 should be detached for Elementary/Secondary (0-12) College (1-4 or 5+) COMPL Rigger Construction Once. 17. FATHER'S NAME (First, Middle, Last) ts. MOTHER'S NAME (First, Middle, Maiden Surneme) John Loving Myrtle Beasley notified at 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Yown, State, Zip Code) 2 11331 Aden Road Nokesville, VA Mrs. Betsy Page must be 20e. METHOD OF DISPOSITION

Marie 2 Cremetion 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State Mount Comfort Cemetery 12/12/95 Alexandria, VA 4 Donetion 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY MOUNTCASTIE Funeral Home examiner Willow Woodbridge, VA 22191 # medical 23. PART I. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiretory arrest, shock, or heart fellure. List only one cause on each line. filled in by ö IMMEDIATE CAUSE (Finel other traumatic event, the cremation. disease or condition spiration Dremous completely resulting in death) DUE TO (OR AS A CONSEQUENCE OF): and com CERTIFICATION Sequentially liet conditions, DUE TO (OR AS A CONSEQUENCE OF): the attending physician ar Mental Hygiene prior to if any, leading to immediate cause. Enter UNDERLYING requires that the death certificate be CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated evente reaulting in death) LAST 0 Injury, PART II. Other aignificent conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY Health and PERFORMED? ingestion a)(dna) any 1 YES 2 NO Shows has been a Dept. of H PHYSICIAN: DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN HOSPITAL DR ATTENDING PHYSICIAN: The law 26. PLACE OF DEATH (Check only one) 25. WAS CASE REFERRED TO MEDICAL Item certificate h the State EXAMINER? HOSPITAL: OTHER:
4 Nursing Homa 5 Residence 8 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED this ce with th marked, 1 Natural 2 Accident 5 Pending Investigation 1 YES 2 NO ВУ After 1 L DIRECTOR: Aft hours after dea item 28 is n 3 Sulcide 28e. PLACE OF INJURY — At home, lerm, street, lectory, office building, etc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 8 Could not be datermined COMPLETED 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end pieca, and due to the cause(s) end manner as stated. TO THE HOSPITAL D TO THE FUNERAL DI be filed within 72 ho IMPORTANT: If ite MEDICAL EXAMINER: On the beals of exemination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the ceuse(s) and menner es stated. 29b. SIGNATURE AND TITLE OF CENTIFIE 띪 2 31. DATE FILED (Month, Day, Year)
DEC 1 8 1995

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

Loving

6. AGE (In vrs. lost birthday) IF UNDER 1 YEAR IF UNDER 24 HRS.

TO THE HOSPITAL OR ATTENDING PHYSICIAN; The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or a	TO THE FUNERAL DIRECTOR; After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for us	death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal,	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
TO THE HOSPITAL OR ATTENDING PHYSICIAN; The law require	TO THE FUNERAL DIRECTOR; After this certificate has been significant to the following the second sec	be filed within 72 hours after death with the State Dept, of He	IMPORTANT: If item 28 is marked, or item 23 shows

	FOR STATE REGISTRAR	STATE OF	MARYLA					EALTH DEAT		MEN	ITAL HYGIEN REG. NO.	_			
3	1. DECEDENT'S NAME (First, Middle	, Lest)								2. E	ATE OF DEATH	NY.	YEAR	3. TIME OF OEATH	
- 1	HEI K.		-								CEMBER 1		995	833A	
	4. SOCIAL SECURITY NUMBER 217-11-0193		5. SEX 1			F UNDER	DAYB	# UNDER	24 HRS.	0	ATE OF BIRTH Worth, Day, Year) CTOBER 1		Countr	IRTHPLACE (State or Foreign ountry) KOREA	
. 1	9a. FACILITY NAME (If not institution	9	9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF OEATH								EATH				
	746 WILTON FARM DRIVE						ALT	LMORI	<u> </u>			BALT	TIMORE		
		COUNTY						ION					10d. INSIDE CITY LIMITS?		
	MARYLAND 100. STREET AND NUMBER	HOWARD			EI	LLIC		CITY						t TYES 2 NO	
	3525 COVENTRY	3525 COVENTRY COURT DRIVE						2104				10g. CIT	U.S.	A.	
5	11. MARITAL STATUS 1 Never Married 2 Marrie 3 Widowed 4 Divorced	12. WAS DECED FORCES? IF YES, GIVI)	13. WAS DECENDENT OF HISPANIC ORIO					RIGIN? (Specify Yes arto Rican, etc.)	— American Indian, , Whita, etc. /y: KOREAN					
	15. DECEDENT (Specify only higher	'S EDUCATION		16a. DECED							16b. KIND OF BUS	SINESS/IN	DUSTRY		
	Elementary/Secondary (0-12)	College (1-4 or 4 YR)						g							
	17. FATHER'S NAME (First, Middle, L	est)			-			16. MOTH	IER'S NA	ME (F	irst, Middle, Maiden	Surname)			
ı	UNKNOWN	KIM						EUI	LEE						
	19a. INFORMANT'S NAME (Type/Prin	nt)									Number, City or Town				
	TED LEE			35	25 0	COVE	NTR	COU	JRT	DR1	VE-ELLI	COTT	CITY	,MD 21042	
	20a. METHOD OF DISPOSITION 1 Burlai 2 Cremation 3	Removal from Stata		PLACE AND etery, cremate			TION (Na	ne ol			DATE 20c. LO	CATION -	City or To	wn, Stata	
	4 Donation 5 Other (Specification of Specification of Spe					IEMO							RIOTTSVILLE		
	* Jackie	D. SK	an	non	_	HUI 410	BBAR 07 W	D FU	NERA NS A	CLTY VE	HOME INC	LTIM	ORE,	MD 21229	
	23. PARTY Enter the diseases, or complications that caused the death. Do not enter the mode of dying, auch as cerdiac or reapiratory arrest, shock, or heart feiture. List only one cause on each line. Approximate interval Batween Onset and Death disease or condition reautiting in death) DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):														
ı	resulting in death) LAST	d													
	PART II. Other aignificent con	nditions contributing	PERFORMEO? AMAILAGE COMMIST.								WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE				
			OF DEATH								OF DEATH?				
	DID TOBACCO USE C	ONTRIBUTE TO C	AUSE OF	DEATH	YES		0 1	UNC	ERTAIN	۷ L	1				
	25. WAS CASE REFERRED TO MEDI EXAMINER?	CAL HOSPITAL:	2	6. PLACE O					/	_					
	t 🗆 YES 2 🖪 NO	1 Inpatient	☐ ER/Outpa	rtlent 3 🗆 I		THER □ Nural		5 Della	sidenca	6 🗆 6	Other (Specify)				
	27. MANNER OF DEATH 1 Natural 5 Pending	28a. OATE (Month	Day, Year)	28	b. TIME O	F :	28c. INJU			26d.	OEŞCRIBE HOW IN	JURY OC	CUREO		
	1 Natural 5 Pending 2 Accident Investig	ation				М	1 🗆 Y	ES 2 _	NO						
		building stc (Specify)										oute Number,			
		PHYSICIAN: To the best (AMINER: On the basis of												and mattner as stated.	
1	296. SIGNATURE AND TITLE OF CE		0	_				29c. LICE							
	1	~	1	n				7	19		2	N 0		(Month, Dey, Year)	
	30. NAME AND ADDRESS OF PERSO DR. SANG CHEOI	DOH - 160	USE DE DEA	TH (ITEM 27) (Type, Pri	ıı GH	WAY	- GI			NIE, MD		106	1 15, 1996	
	DEC 1 8 1995	Javi a turilla		URE .									, , ,		

97 . 9 .7

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death **Physician** DEC. P3 1995 ELIZABETH MARY LUMADUE 12:45 PM /Medical 4a. Facility Nama (If not institution, giva street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 3810 FAIRHAVEN AVENUE BALTIMORE CITY If Undar 1 Yaar If Undar 24 Hrs. 8. Data of Birth (Month, Day, 5. Social Sacurity Numbar 6. Sax 7. Aga (In yrs. last birthday) Birthplaca (Stata or Foraign Country) **Funeral** 1 □ M 2 17 E Yrs. June 8, 176 30 4182 Director 58 1937 Pennsylvania Usual Rasidance of Decedant 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits ms 23a or 28a-f show Maryland N/A Baltimore ¥ Yas 2 No Director 2 10e. Street and Numbar 10f. Zip Coda 10g. Citizen of What Country? or flems 23s or 21226 U.S. 3810 Fairhaven Avenue Funeral 12. Was Decedant Evar In U,S. Armed Forcas? 1 ☐ Yas 2X No Was Decedant of Hispanic Origin? (Specify Yas or No if Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Raca - Amarican Indian, Black, Whita, atc. urs after 1 Navar Marriad 2 Married If Yas, Giva Yaar or Datas 1 ☐ Yas 2 No Specify: à Specify: White 3 ☐ Widowad 4 Divorced Ä Completed 16a. Decedant's Usual Occupetion 16b. Kind of Business/industry 15. Dacedant's Education (Specify only highast grada complated) (Giva kind of work dona during most of working lifa. DO NOT usa retired) North American Elamantary/Secondary (0-12) Coilega (1-4or 5+) Accountant 12th Beauty Services 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maiden Sumama) altimore, Maryland Be 0 Elizabeth Shields John M. Cummings Pages 1 and 2 should pug a 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Department of Health Important: If Item 27 Glen Burnie, Maryland 21060 Richard Kelser 142 Northdale Road 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 ☐ Burial 2 XCramation 3 ☐ Ramovai from Stata 4 ☐ Donation 5 ☐ Othar (Specify) Metro Crematory, Inc. 12/15 Baltimore, Maryland 21. Signatum of Funaral Sarvice Licensee 22. Nama and Addrass of Facility George J. Gonce Funeral Home P.A. ramerous 21225 4001 Ritchie Highway Baltimore, Md. infications that caused tha death. Do not antar the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Approximata Intarval Batween Onset end Death Physician Immediata Causa (Final disaasa or condition rasulting in daath) /Medical Arteriosclerotic Cardiovascular Disease Examiner Dua to (or as a consequence of) Examiner The law requires that the deeth certificate be axecuted burial-transit Sequantially list conditions, if any, laading to immadiata cause. Entar Undarlying Causa (Disaasa or Injury Dua to (or as a consequence of): Box 68760. attending physician for use es the burie Physician/Medical that initiated evants Dua to (or as a consequence of) rasulting In daath) Last Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yee 2 ☐ No signed to **EMPHYSEMA** þ been si 24b. Wara autopsy findings available prior to Completed 24a. Was an autopsy completion of cause of death? page 2 s certificate 1 Yas 3(3No 1 Yas 2 No or Attending Physician: Be 25. Was casa rafarred to medical 26. Placa of Death (Check only ona) Othar: 4 Nursing Homa Masidanca 6 Othar (Specify) XX as 2 No 2 After this funeral dir 1 Inpetiant 2 ER/Outpetlent 3 DOA 28b. Tima of Injury 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28d. Dascribe how injury occurred Aftert 5 Panding invastigation 1 Natural 2 Accidant death. 1 ☐ Yas 2 ☐ No after death
Director: A 6 Could not be datarmined 3 ☐ Suicida 28a. Place of Injury - At homa, farm, streat, factory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 4 Homicide within 24 hours a

To the Funeral D

completely filled 1 Certifying Phyeician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Provided Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only 29b. Signatura and titla of certifier 29c. Licansa number 29d. Data signed (Month, Day, Year) DEC. 13,1995 O.C.M.E. 30. Nama and addrass of person who complated causa of death (Itam 23a) (Type, Print) Dennis Chute M.D. 111 Penn Street, Baltimore, Maryland 21201

DHMH 16 Rev 6/95

State

Registrar

31. Data filed (Month; Day, Year)

CC 1 8 1995

32. Registrar's Signatura

20 To present the partners of the partners of the second s

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physicis	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-t	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the	TO THE FUNERAL DIRECTOR: After this certificate has been signed by	be filed within 72 hours after death with the State Dept. of Health and	IMPORTANT: If item 28 is marked, or item 23 shows any li

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

1 - FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

1 DECEMBRY: NAME (First, Middle, Last)

2 DATE OF DEATH

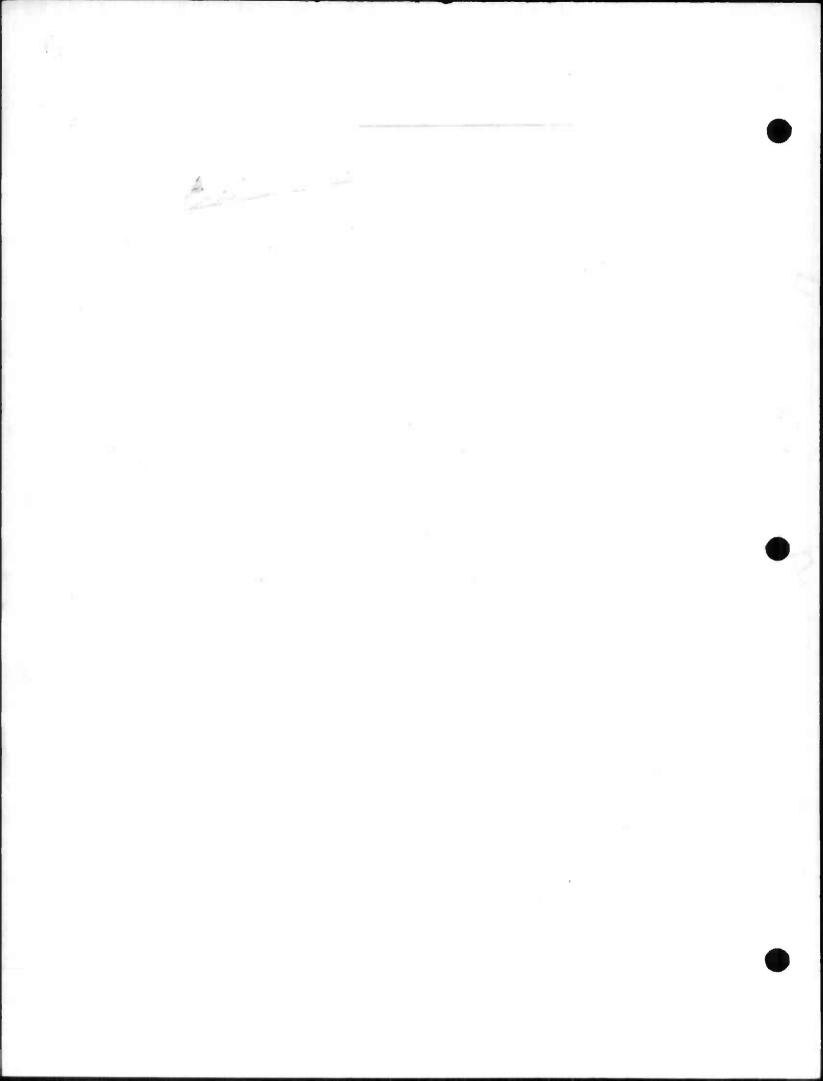
* REGISTRAR				CERTIF	ICAI	E OF	DEA	I H		REG. NO.			
1. DECEDENT'S NAME (First,									2. DATE OF MONTH	DEATH DA	V 005	YEAR	3. TIME OF DEATH
VIRGIL L.							1		DEC.		1995		2:30 P.M.
4. SOCIAL SECURITY NUMBER 246-32-3955		5. SEX 1X M 2 F	6. AGE (In yo	rs. last birthday) YRS.	MONTHS	DAYS	HOURS	MIN.	7. DATE OF (Month, D JUNE	imr Manri	1927	Country	PLACE (State or Foreign) H CAROLINA
9a. FACILITY NAME (If not ins	itution, give stre	set end number)			9b. CI1	ry, TOWN	OR LOCATI	ON OF D	EATN		9c. COU	NTY OF DE	ATN
6508 WINDSO		RD., W			WO	ODLA	WN				BAI	TIMO	RE
10e. STATE	10b. COUNTY			10c. CIT	Y, TOWN	OR LOCA	TION					- 1	10d. INSIDE CITY LIMITS?
MARYLAND	BALTI	MORE		WOO	DDLA	.WN							1 YES 2 NO
10e. STREET AND NUMBER						10	f. ZIP COD						HAT COUNTRY?
6508 WINDSO	R MILL	RD., W					2120	07			LIND	ED S	TATES
11. MARITAL STATUS 1 Never Married 2 1 3 X Widowed 4 Divor	Astried	12. WAS DECEDENT FORCES? 1 IF YES, OIVE W	X YES 2	2 NO	13	It yes, s		n, Mexica	NIC ORIGIN? (in, Puerto Rici y:		or No-		— American Indian, White, etc.
15 DECE	DENT'S EDUC			e. DECEDENT'S	LANGELLE	OCCUPAT	ON.		T seb at	ND OF BUS	NESS/INC	MISTRY	WIIII
(Specify only	highest grade o	completed)		(Give kind of life, Do NOT u	work don	e during m	ost of worki	ng	100. 10	ND OF BOO	3111E 337111E	, ooini	
Elementary/Secondary (0- 12	12)	College (1-4 or 5 +		LABELE		,			PA	CKAG:	ING		
17. FATHER'S NAME (First, Min	fella (aut)						T 16 MOT	MED'S NA	ME (First, Mid			-	
DEWEY LANE	rune, carst)								BALL	une, renueri	Surname)		
	477-1			T 405 44 4 1 1 1 1		00 (0)				Oh T.	- Danie 71	0-4-1	
190. INFORMANT'S NAME (T)				1					Route Number, W.,				21207
02222				1									
20a METHOD OF DISPOSITION 1 Suriei 2/1 Cremetto 4 Donatton 6 Other	Specifier		cemeter GLE	ACE AND DATE ry, crematory or o N HAVE	other plac ME	М. Р	K.	199	5			RNIE,	MARYLAND
21. SIGNATURE OF FUNETON	ENVICE LICE	ENTER E	2		K	IRKI		UDDI	CK FUN				E, MD 2106
23. PART I. Enter the dishock, or he IMMEDIATE CAUSE (Fin disease or condition resulting in death)	art fallure. L	List only one cau	se on each	h Ilne.				/ing, suc	n aa cardle	c or reap	iratory an	reat,	Approximate interval Batwee Onset and Das
if any, leading to immed cause. Enter UNDERLY	equantially list conditions, any, leading to immediate susse. Enter UNDERLYING AUSE (Disease or injury lat initiated events												
PART II. Other algnifica	nt conditions	contributing to	death but	not resulting	In the	underlyi	ng ceuse	given in	Part I. 2	4a. WAS AN		24b.	WERE AUTOPSY FINDING AMAILABLE PRIOR TO
		<u> </u>							_ 1	YES 2	- DAP		COMPLETION OF CAUSE DF DEATH? 1 YES 2 PAO
DID TOBACCO U	SE CONTR	RIBUTE TO CA	USE OF	DEATH Y	ES 🗹	NO [] UN	CERTAI	N 🗆				
25. WAS CASE REFERRED TO EXAMINER?		HOSPITAL:	100 -00	PLACE OF DEA	ОТН	ER:		lesidence	6 Other	Specify)			
	Pending	28e. DATE OF (Month, D		26b. TII		28c. IN	JURY AT	□ NO	28d. DESCI		INJURY OC	CURED	
3 Suicide 6	nvestigation Could not be letermined		of INJURY — etc. (Specify)	At home, term,	atreet, f					ION (Street Town, State)		r or Rural R	loute Number,
One)) end manner en stated.	
29b. SIGNATURE AND TITLE	OF CERTIFIER						29c 116	CENSE NII	MBER		29rl DA1	TE SIONED	(Month, Dev. Year)
30 NAMES AND ADDRESS OF	DEBSON Maio	COMPLETED CALL	SE DE DEAT	N /ITEM 27 /T-	a Dolors			10	0 30		U	COM	my 13, 1791
29e. CERTIFIER (Check only one) 2 MEDI	xamination •	wiedge, desth occurred at the time, date end place, and due to ion end/or investigation, in my opinion, death occured at the to 29c. LICENSE NUMBER OF A SEATH (ITEM 27) (Type, Print) D 900 CATOW AVE BA					e time, data er	(Month, Day, Yes					

of INA DHMH-16 Rev 1/89

on months in

ITEM1.a-730.12-18-95.perf.h..dk

	1. DECEOENT'S NAME (First, Middle, Last	FILLIAM OUNCAN	CLASH MON	ROE		2. DATE OF DEATH DAY							
	4. SOCIAL SECURITY NUMBER	IHIAN	1100	FOR		Der. 1-	3 9)) 74 M					
		5. SEX 8. AGE (III 95	yrs. lest birthday)	MONTHS DAYS	HOURS MIN.	(Month, Day, Year)	Co	RTNPLACE (State or Foreign untry)					
	378-05-0593 D	Λ	YRS.			Jan 1, 19		aryland					
R	Bon Secours Hosp			200	or Location of OE timore	ATN	9c. COUNTY O	n/a					
CTOR	RESIDENCE OF DECEDENT 10a, STATE 10b, COUN		T.o. em										
DIRE			10c. CIT	Y, TOWN OR LOCAT				10d. INSIDE CITY LIMITS?					
. 10-	Maryland 100. STREET AND NUMBER	n/a		Baltimo	re I. ZIP CODE		40- OSTITEN	TXXYES 2 NO					
FUNERAL		where December		101			ing. Citizen	DF WHAT COUNTRY?					
Z.	701 North Arling	12. WAS DECEDENT EVER IN	U.S. ARMED	13 WAS DEC	21217	IIC ORIGIN? (Specify Yes	or No 14 6	USA ACE — American Indian,					
- 11	1 Never Merried 2 Merried	FORCES? 1 YES	2 X NO	If yes, sp	ecity Cuben, Mexica	n, Puerto Ricen, etc.)		lack, White, etc.					
B	3 Widowed 4 Divorced	II TES, GIVE HAN ON DA	123	1 1 163	2 X NO Specify		,	Black					
	15. DECEOENT'S ED (Specify only highest green)		16a. DECEDENT'S	USUAL OCCUPATION	ON ast of working	16b. KIND OF BUSI	INESS/INDUSTR						
	Elementary/Secondary (0-12)	College (1-4 or 5+)	Ille. Do NOT u	se retired.)	or or or or or or or or or or or or or o								
COMPL	6th Grade		Lau	ndry Wor	ker	Camp 1	Meade						
8	17. FATNER'S NAME (First, Middle, Lest)				18. MOTHER'S NA	ME (First, Middle, Maiden S	Sumeme)						
BE	Archibald Clash				Carri								
2	190. INFORMANT'S NAME (Type/Print)					Houte Number, City or Town,							
	John Clash				sedale S		ltimore						
	20a. METHOD OF DISPOSITION 1A Burlel 2 Cremation 3 Re		etery, crematory or o	OF DISPOSITION (Na ther place)		Dec	ATION — City of						
	4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE 1		ltimore	Nationa 22 NAME AL	1 Cemete	LA 18 par	Funore,	Maryland					
	22. NAME AND ADDRESS OF FACILITY Nutter Funeral Homes, Inc. 2501 Gwynns Falls Parkway												
33	Baltimore, Maryland 21216												
	23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ahock, or heart feliure. List only one ceuse on each line. Approximate interval Betw												
	IMMEDIATE CAUSE (Final												
	resulting in death)	· ST.50	KC					one day					
- 1		OUE TO (OR AS A	CONSEQUENCE O	1/1/00	clerone								
Z O	Sequentially list conditions,	DUE TO (OR AS A			curon	\$							
Ē	If any, leading to immediate cause. Enter UNDERLYING	DOE TO (OR AS A	CONSCOUENCE	₹):									
윤	CAUSE (Disease or injury that initiated events	C. DUE TO (OR AS A	CONSEQUENCE O	F):				1					
CERTIFICATION	reaulting in deeth) LAST												
¥	PART II. Other significant conditions	ons contributing to death be	it not resulting	In the underlyin	g ceuse given in	Part I. 24a. WAS AN / PERFORI		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO					
MEDIC	uninen	Tract infe	cuon	will	Sepas	1 YES 2.	NO	OF DEATH?					
ME		V						1 _ YES 2 _ NO					
ä	DID TOBACCO USE CON					V 🗆							
SICIAN	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:		TH (Check only one) OTHER:	1								
ΥS	1 YES 2 NO	1. Inpetient 2 ER/Outp		4 - Nursing Hon	ne 5 🗆 Residence								
PHY	27. MANNER OF DEATN 1 Tritural 5 Pending	(Month, Day, Year)	28b. TIN	JURY WO	JURY AT ORK?	28d. OEŞCRIBE HOW IN	IJURY OCCURE	0					
BY	2 Accident Investigation	28e. PLACE OF INJURY	At home form		YES 2 NO	201 0007101 (011	-11						
8	3 Suicide 8 Could not b 4 Homicide determined	building, etc. (Spec	ify)	street, factory, offic		28f. LOCATION (Street e. City or Town, State)	nd Number of Hi	rai Houte Number,					
	290. CERTIFIER CERTIFYING PHY	YSICIAN: To the best of my knowl	ados desth occur	and at the time date	and place, and due	to the covered and man							
5	(Check only							se(e) end menner ee stated.					
5	onel		_										
COMPLET	one) 2 MEDICAL EXAMI				ZO. LICENCE MIN	IDED	004 DATE 010	100 At - 1 D - 10 - 1					
5	onel		MD		29c LICENSE NUI	BER (2.7	29d. DATE SIG	NED (Month: Day, Year)					
E COMPLET	29b. SIGNATURE AND TITLE OF CERTIF		M)	a, Print)	D39	127	D 12.	NED (Month, Day, Year)					



FilmG, 730, item #1,7, 12/18/95,cyw, per f.h.

		1 - FOR STATE OF MARYLAND C	DEPARTMENT OF PERTIFICATE OF		MENTAL HYGIENE REG. NO.		
•		1. DECEDENT'S HAME (Munika) MONICA AGATHA MONICA A. M. GARLE			2. DATE OF DEATH MONTH	95 3.	TIME OF DEATH
, pin		4. SOCIAL SECURITY HUMBER 212-16-8278 5. SEX 1	YRS. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN,	06031	12 8. BIRTHPLA Country)	ACE (State or Foreign MRYLAN)
1, 2, 3 should	TOR	PARTH ARUNDEL HOSPITAL RESIDENCE OF DECEDENT		OR LOCATION OF DEA		PC. COUNTY OF DEAT	
nit. Pages	DIRECTOR	Maryland N/A	Baltimore	(Curtis	Bay)		d. INSIDE CITY LIMITS? YES 2 NO
an. transit permit	FUNERAL	100. STREET AND NUMBER 4216 Grace Court		21226		10g. CITIZEN OF WHAT USA	T COUNTRY?
215-0020 attending physician. se as the burlal-transit	B	11. MARITAL STATUS 1 Never Merried 2 Married 3 Wildowed 4 Divorced 12. WAS DECEDENT EVER IN U.S. A FORCES? 1 YES 2 IF YES, GIVE WAR OR DATES	NO II yes, sp	CEHDENT OF HISPANIC pecify Cuban, Mexican, 8 2 X HO Specify:	C ORIGIN? (Specify Yes or , Puerto Rican, etc.)	r No— 14. RACE — Black, W Specify:	American Indian, Thite, etc. White
21 21 21	PLETED	(Specify only highest grade completed)	DECEDENT'S USUAL OCCUPATION (Give kind of work done during mode. Do NOT use retired.) Homemaker	OH ost of working	HOUSEWI	fe and Mo	ther
Z & 8	e complet	17. FATHER'S MAME (First, Middle, Last) Edward Domanowski (Jan Dom		16. MOTHER'S NAM	NE (First, Middle, Maiden Su		
, MA be retain ge 5 sho	TO BI	Mrs. Joan M. Jordan	107 Glenlea	a Drive, G	Glen Burnie	e, Md. 210	
AOF ne 6 m nector.	must	4 Donation 5 Other (Specify)	EAHDDATE OF DISPOSITION (Ne	ery Dec. 1	L9, '95 Bal		laryland
Z .	al examiner	tur E El Kevin E.	237	E. Pataps	ral Home of sco Ave., B	Balto., Md	
	nt, the medical	23. PART Enter the diseases, or complications that caused the disease shock, or heart failure. List only one cause on each lin IMMEDIATE CAUSE (Final disease or condition resulting in death)	16.			lory arrest,	Approximate Interval Between Onset and Death
68760 secuted with and comple burlat, on	ON ON	disease or condition a. CEPEBRD V DUE TO (OR AS A CONSE Sequentially list conditions,	EQUENCE OF):	protion	√		
BOX.	RTIFICATION	If any, leading to immediate	40 PATITY				
S, P.O. death on a attenting	~ W	resulting in death) LAST					
	shows any injury, MEDICAL C	PART II. Other significant conditions contributing to death but not	resulting in the underlying	g cause given in Pa	24a. WAS AN AU PERFORME 1 YES 2	ED? AVA	RE AUTOPSY FINDINGS ALABLE PRIOR TO MPLETION OF CAUSE DEATH?
2 0 2		DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEA				10	YES 2 W NO
는 수 일을	YSICIAN:	EXAMINER? 1 VES 2 NO HOS-ITAL: 1 Unpetient 2 ER/Outpatient:	OTHER: 3 DOA CHER:	ne 5 🗆 Residence 6	☐ Other (Specify)		
O H sight	marked, or BY PHY	27. MANNEP*OF DEATH 1 Netural 5 Pending 2 Accident Investigation		URY AT DRK? YES 2 NO	26d. DESCRIBE HOW INJU	URY OCCURED	
TISIO TITENDI TIOR: A after 6	m 28 is	3 Suicide 6 Could not be determined 28e. PLACE OF INJURY — At he building, etc. (Specify)	ome, larm, street, factory, office	a 2	281. LOCATION (Street and City or Town, State)	Number or Rural Route	Number,
\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	MP I	29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the basis of examination and/or					d menner as stated.
TO THE HO TO THE FL De filed wi	TO BE COI	296. SIGNATURE AND TITLE OF CERTIFIER		29c. LICENSE NUMB	77	December	16 1995
		ANOW DETUND. 30/ A	EM 27) (Type, Print)	E GLE	N Burn	E Ms	21061,
		DEC 1 8 1995	on Rardall				

730, item #1, Amended #31 see #32
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL

95)	3	Ö	4	-
DVI		(C	ΥW)	

	1 - STATE REGISTRAR	OTAL OF MARTIE		ICATE OF		REG.	NO.					
	1. DECEDENT'S NAME (First, Middle, Last,)				2. DATE OF OEATH		YEAR 3	. TIME OF DEATH			
	MOODY CE	GI GI	EORGE M	OODY		Dec	17	1995	6 mm M			
	4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE (In yra. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year	r)	8. BIRTHPI Country)	LACE (State or Foreign			
	251-03-9029	1 □XM 2 □ F 79	YRS.	MONTHS DAYS	HOURS MM.	JAN 15,			A CAROLINA			
	9e. FACILITY NAME (If not institution, give	street end number)		9b. CITY, TOWN	OR LOCATION OF E			UNTY OF DEA	NTH			
DIRECTOR	BON SECOURS HOSP	'ITAL		BA	LTIMORE			BALTIN	MORE CITY			
2	RESIDENCE OF DECEDENT 10e. STATE 10b. COUN	TY	10c CIT	Y, TOWN OR LOCA	TION			T,	Od. INSIDE CITY			
E	MARYLAND BALT	'IMORE CITY			ALTIMORE	:			LIMITS?			
1	10g. STREET AND NUMBER				H. ZIP CODE		10a C		AT COUNTRY?			
FUNERAL	1014 W. CROSS ST	REET			21230)	1 1 1 2 2	U.S.A.				
Ş	11. MARITAL STATUS	12. WAS DECEDENT EVER IN FORCES? 1 YES	U.S. ARMED			ANIC ORIGIN? (Specify can, Puerto Rican, etc.		14. RACE -	- American Indian, White, atc.			
ВУ	1 Never Merried 2 Merried 3 Wildowed 4 Divorced	IF YES, GIVE WAR OR DA	TES AND		S 2 XNO Spec			Specify:				
8	15. DECEDENT'S ED	UCATION	16a. DECEDENT'S	USUAL OCCUPAT	ION	16b. KIND OF	BUSINESS/II	NDUSTRY				
ET	(Specify only highest grad Elementary/Secondary (0-12)	College (1-4 or 5+)	(Give kind of life, Do NOT u	work done during m se retired.)	ost of working							
AP.	8TH GRADE		FLOOR	SANDER		CC	NSTRU	CTION				
COMPLETED	17. FATNER'S NAME (First, Middle, Last)					AME (First, Middle, Me	den Surname)				
BE (UNKNOWN				UNKN	IOWN			- CO 6 1			
10	19e. INFORMANT'S NAME (Type/Print)					Route Number, City or			21220			
	KATHERINE J. MOC					ET - BALTI			21230			
	20e METHOD OF DISPOSITION 1 D Burtal 2 Cremation 3 Re	moval from State 20b	PLACE AND DATE		lame of LIAL PARK			— City or Town	n, State			
	4 Donation 5 Other (Specify)		ADOWKID		AND ADDRESS OF F		ELKRI	.DGE				
	200 6	0 1		HUBBA	RD FUNER	RAL HOME,						
	Jello".	Dmil		4107	WILKENS	AVENUE-BA	ALTIMO	RE, MI	21229			
CERTIFICATION	23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition) resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):											
	PART il. Other algnificant condition	ona contributing to death b	ut not resulting	in the underlyi	ng cause given i	n Part I. 24a. WAS	AN AUTOPS	Y 24b. V	YERE AUTOPSY FINDINGS			
DICAL							FORMED?		WAILABLE PRIOR TO COMPLETION OF CAUSE			
MED							3 2 7110		OF DEATH?			
	DID TOBACCO USE CON	TRIBUTE TO CAUSE O	F DEATH Y	ES NO [UNCERTA	IN 🗹						
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?		28. PLACE OF DEA)							
YSI	1 YES 2 NO	HOSPITAL: 1 Impatient 2 ER/Outp	atlent 3 🗆 DOA	OTHER: 4 Nursing No	me 5 🗆 Residence	8 Other (Specify)						
PH	27. MANNER OF DEATN	28e. DATE OF INJURY (Month, Day, Year)	28b. TII		JURY AT ORK?	28d. OESCRIBE NO	W INJURY C	CCURED				
BY	1 Natural 5 Pending 2 Accident Investigation				YES 2 NO							
ED	3 Suicide 8 Could not be determined 6 Homicide 6 Homicide 6 Homicide 6 Homicide 6 Homicide 6 Homicide 6 Homicide 6 Homicide 6 Homicide 6 Homicide 6 Homicide 6 Homicide 6 Homicide 6 Homicide 6 Homicide 6 Homicide 6 Homicide 7 Homicide 8 Homici											
Ш	290. CERTIFIER 1 CERTIFYING PNY	(SICIAN: To the heat of my know	lados, desth occur	and at the time day	to and place and di							
COMPLET	CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the ceuse(s) end menner as stated. CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the ceuse(s) end menner as stated.											
	29b. SIGNATURE/ANO TITLE OF CERTU	ER /			29c. LICENSE N							
BE	11. Mart	are do-MA			Zyc. LICENSE N	933	290. D		Month, Day, Yeer)			
2	30. NAME AND ADDRESS OF PERSON W	WNO COMPLETED CAUSE, OF DE	ATN (ITEM 27) (Tvn	e, Print)	10'	1133		, /	1-75			
	JUAN R.	PAREdes										
	31. DATE FILED (Month, Day, Year) 12 - 17 - 95	DEC 18 199	15 Julia	Savelen A	ardall							

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physical TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the buriable filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, P.O. BOX 6876

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TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit be filled within 122 hours after death with the State Dept. of Health and Merital Hygiene prior to burial, cremation, or removal.

1 - STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

		HEOISTHAN			LHIII	ICALE	UF	DEAL		R	EG. NO.			
		1. OECEDENT'S NAME (First, Middle, Last) Melvin Mack	<u> </u>							Dec.		199	_ YEAR	O:30A M
		4. SOCIAL SECURITY NUMBER 088-03-1005	1 🖾 M 2 🗆 F	8. AGE (In yrs. Is 8 4	yrs.	IF UNDER MONTHS	1 YEAR DAYS	IF UNDER	24 HRS.	7. DATE OF 8 (Month, Day July	интн у. Year) 27,	191	A BIDTHOL	ACE (State or Foreign
Ι.		9e. FACILITY NAME (If not institution, give s	treet end number)			9b. CITY,	TOWN C	OR LOCATIO	ON OF DEA				INTY OF DEA	тн
act Jane	2	5025 Green Moun	tain Ci	rcle	# 3	С	olu	mbia	a			Но	ward	
l ù	Í	10e. STATE 10b. COUNTY			10c. CIT	Y, TOWN O	R LOCAT	TION					1	Dd. INSIDE CITY
		Maryland How	ard			Colu								LIMITS?
DV EINEDAL	Y L	5025 Green Moun	tain Ci	rcle,	#3		101	2104					S A	AT COUNTRY?
1 2	5	11. MARITAL STATUS	12. WAS DECEDENT	EVER IN U.S. A	RMED	13. \	WAS DEC	ENDENT O	F HISPANIC	C ORIGIN? (S	pecify Yes			- Americen Indian, White, etc.
	_	1 Never Married 2 Married 3 Wildowed 4 Divorced	FORCES? 1 [IF YES, GIVE WA	R OR DATES	X		T yes, spe	2 NO	n, Mexican, Specify:	, Puerto Ricar	i, etc.)			ite
Į.	3	15. DECEDENT'S EDUC (Specify only highest grade	CATION completed)	16a, D	ECEDENT'S Give kind of	USUAL OC	CUPATIO	ON of working		16b, KIN	D OF BUS	INESS/IN		
COMPI ETEN		Elementary/Secondary (0-12)	College (1-4 or 5 +)		u. Do NOT u	se retired.)	Juling mu	St OF WORKING	9			0		
2 2		17. FATHER'S NAME (First, Middle, Last)		1	Engi	reer	-			_			mpany	
		Leonard Mack								e Sel				
E A	5	19e. INFORMANT'S NAME (Type/Print)		146	Ob MAILING	ACCRECE	/Stenat a			oute Number, C				
5	2	Edward Mack												21045
100		20a. METHOD OF DISPOSITION 1.△ Burlet 2 ☐ Cremation 3 ☐ Rema	oval from State	20b. PLACE	ANDDATE	OF DISPOS	ITION /No.	me of		DATE	20c 100	CATHON -	City or Town	State
5	į	4 Donation 5 Other (Specify)		Colum	nbia					2-11	Со	luml	bia,	Md.
aye		→ Lyn D	(x), OOLO	im 5		Ιv	es-		son	Fune , Va.				
		23. PART I. Enter the diseeses, or o	complications that	caused the d	esth. Do i	not enter	the mod	de of dyle	ng, such	as cardiac	or respli	ratory an	reat.	Approximate
		MANSPLATE CALLES (FIg.)	List only one cause	e on aach lin	Θ.		,					2,0		Interval Between Onset and Death
The state of the s		disease or condition resulting in death)	NON-S	OR AS A CONSE	OUENCE O	Die		7		7 0-7				12 months
N		Sequentially list conditions,	A					U						
AT A		if any, leading to immediate cause. Enter UNDERLYING	DUE TO (O	R AS A CONSE	OUENCE O	F):								
CERTIFICATION		CAUSE (Disease or Injury that Initiated events resulting in death) LAST	DUE TO (O	R AS A CONSE	OUENCE O	F):								
		resulting in death) Exst	d											
	- 111	PART II. Other algnificant condition	contributing to d	eath but not	resulting	n the un	derlying	cause g	Iven in P	ert I. 24s.	WAS AN	AUTOPSY	24b, W	ERE AUTOPSY FINDINGS
FDICAL											PERFOR		A	MILABLE PRIOR TO OMPLETION OF CAUSE
	1									- ''	YES 2	X NO		DEATH?
2		DID TOBACCO USE CONTR	SIBUTE TO CAU	SE OF DEA	ATH VE	SIN	JO [LINC	ERTAIN	-				YES 2 NO
N A		25. WAS CASE REFERRED TO MEDICAL	MIDOIL IO GITO		CE OF DEA			OITC	LKIAIII				1 .	
Sic		EXAMINER?	HOSPITAL:	R/Outpatient :	3 DOA	OTHER 4 Num		600	uldamas d	Other (Spi				
PHYSICIAN		27. MANNER OF DEATH	28e. DATE OF IN	JURY	28b. TIM	E OF	28c. INJU	URY AT	_	28d. DESCRIB		JURY OC	CURED	
BY P		1 Natural 5 Pending 2 Accident Investigation	(Month, Day,	7	NI	/		ES 2 _			NIF	7		
9		3 Suicide 8 Could not be 4 Homicide determined	28e. PLACE OF building, et	INJURY — At he c. (Specify)	_	dreet, facto	ory, office			281, LOCATION City or Tow	N (Street ei	nd Number		e Number,
1		29e. CERTIFIER (Check only	CIAN: To the best of m	y knowledge, de	eath occum	d at the tis	me, date	end place,	end due to	the cause(s)	end men	ner as star	ted.	
COMPLET		one) 2 MEDICAL EXAMINE												nd menner es stated.
BE C		29h SIGNATURE AND TITLE OF CERTIFIER							NSE NUMB					grith, Day, Year)
2	-	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE	OF OEATH (ITE	M 27) (Type	Print)		4	-11 5	/		- 1	-113/	73
1	1	11065 Little	. Potus	ent (Park) ,	Col	hub	í .	m)	6	2016	VIEW4
		18 1995	A PASCLEON A	SIGNATURE		4								

DHMH-16 Rev 1/89

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JOR.	afte	IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detache	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detache be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burfal, cremation, or removal.

5

	FOR STATE REGISTRAR	STATE	OF MARYL			TMENT				MENTAL	HYGIEN	E				
	1. DECEDENT'S NAME (First, Middle MILD RE			MOR		√				MONTH	OF DEATH DA		YEAR 1995	3. TH	ME OF DEATH 7-45P	м
	4. SOCIAL SECURITY NUMBER 213-01-3918	5. SEX 1 M 2	X F	(In yrs. lest b	YRS.	IF UNDER	DAYS	IF UNDER	MIN.	NOV.	30,190		Ma	iry.	e (State or Foreign land	
TOR	9a. FACILITY NAME (If not institution Harford Gardens RESIDENCE OF DECEDE	S	er)					R LOCATION OF COLUMN 1					time		City	
FUNERAL DIRECTOR	10a. STATE 10b.	COUNTY Baltimore	City		10c. CIT	у, тоwн о Ва		nore	City	/				1	INSIDE CITY LIMITS? YES 2 \(\square\) NO	
ERAL	100. STREET AND NUMBER 5812 Moores Rui	n Court					101.	ZIP CODE	21200	6			ZEN OF W	/HAT (COUNTRY?	
	11. MARITAL STATUS 1 Never Married 2 Marrie X Widowed 4 Divorced	FORCES	CEDENT EVER II ? 1 TYES GIVE WAR OR D	ZX XNO		1	f yes, spe			n, Puarlo R	? (Specify Yes licen, etc.)	or No—	14. RACE Black Speck	t, White	merican Indian, la, etc. hite	
COMPLETED BY	15. DECEDENT (Specify only higher Elementary/Secondary (0-12) 5th grade 17. FATHER'S NAME (First, Middle, L	r's EDUCATION st grade completed) College (1-		(Give life. D	kind of v	usual od work done d se retired.) eria	CUPATIO during mos	at of workin		N	kind of Bus	tile	DUSTRY		18	
BE CO	Henry W. Hipps Ruby Lambert Rub															
임	Margaret Chris	t	200						ornani							
206. METHOD OF DISPOSITION AXX Burlet 2 Cremetton 3 Removal from State 4 Donation 6 Other (Specify) 205. PLACE AND DATE OF DISPOSITION (Name of Cametery, Clemetery of the Cametery, Clemetery 12-16-95 206. LOCATION — City or Town, State 207. PLACE AND DATE OF DISPOSITION (Name of Cametery, Clemetery) 208. PLACE AND DATE OF DISPOSITION — City or Town, State 209. PLACE AND DATE OF DISPOSITION (Name of Cameter) 209. PLACE AND DATE OF DISPOSITION — City or Town, State 209. PLACE AND DATE OF DISPOSITION — City or Town, State 209. PLACE AND DATE OF DISPOSITION (Name of Cameter) 209. PLACE AND DATE OF DISPOSITION (Name of Cameter) 209. PLACE AND DATE OF DISPOSITION (Name of Cameter) 209. PLACE AND DATE OF DISPOSITION (Name of Cameter) 209. PLACE AND DATE OF DISPOSITION (Name of Cameter) 209. PLACE AND DATE OF DISPOSITION (Name of Cameter) 209. PLACE AND DATE OF DISPOSITION (Name of Cameter) 209. PLACE AND DATE OF DISPOSITION (Name of Cameter) 209. PLACE AND DATE OF DISPOSITION (Name of Cameter) 209. PLACE AND DATE OF DISPOSITION (Name of Cameter) 209. PLACE AND DATE OF DISPOSITION (Name of Cameter) 209. PLACE AND DATE OF DISPOSITION (Name of Cameter) 209. PLACE AND DATE OF DISPOSITION (Name of Cameter) 209. PLACE AND DATE OF DISPOSITION (Name of Cameter) 209. PLACE AND DATE OF DATE																
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AL.	PART II. Other algorificent co		ng to death t	out not rea	ulting	In the un	derlying	ceuse (given in	Part I.	24a. WAS AN PERFOR	MED?	24b	COMP OF D	E AUTOPSY FINDING ABLE PRIOR TO PLETION OF CAUSE EATH? YES 2 NO	
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ВУ Р	1 Natural 5 Pendir 2 Accident Invest	ng igation (M	onth, Day, Year)		INJ	M	1 Y	PK7 'ES 2 [] NO		ATION (Street)			Doub f	Managara	
ETED	3 Suicide 8 Could 4 Homicide daterm	not be bu	iliding, etc. (Spe	cify)						City	or Town, State)			10010	vumber,	
COMPLETED	29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On this basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated. MEDICAL EXAMINER: On this basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated.															
TO BE (29b, SIGNATURE AND TITLE OF C	Ladi	an	===				29c. LICI P.C	ense nun	OS		29d. DAT	E SIGNED	(Mont	In. Day. Year)	>
	30. NAME AND ADDRESS OF PERSON AY P. 31. DATE FILED (Month, 'Day,' Year)	PRAD	D CAUSE OF DE HAN SISTRAR'S SIGN	600		SAM	ARIT	AN	H	SPIT	AL,	BALT	IMO	RE	, MDZ12	39.
	DEC 8 1995	1	ASTRAR'S SIGN	-											DHMH-16 Rev	1/00
	,	Appendix 10-de													P. 11. 11. 12. 12. 12. 12. 12. 12. 12. 12	1102

n a

		1 - FOR STATE REGISTRAR	STATE OF MARYLA	ND / DEPARTM	MENT OF H	EALTH AND		YGIENE EG. NO.				
		1. DECEDENT'S NAME (First, Middle, Last	Joan P. Cas		hews		2. DATE OF C	DEATN DAY	YEAR	3. TIME OF DEATH		
Py		4. SOCIAL SECURITY NUMBER 218 03 3243	1 □ M 2 🔀 F 75	1.	UNDER 1 YEAR NTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF B (Month, Day	IRTH	8. BIRTHPI Country)	11:00 A. 1 LACE (State or Foreign yland		
. 2, 3 should	TOR	90. FACILITY NAME (If not institution, give 4333 Berger A			Baltime	OR LOCATION OF D			UNTY OF DEA			
ift, Pages 1	DIRECTOR	10a. STATE 10b. COUN	ne Arundel		own or locat					10d. INSIDE CITY LIMITS? 1 YES 2 X NO		
an. ransit permit.	FUNERAL	450 Phirne Cou			101	21061		100	U.S.A.	HAT COUNTRY?		
IARYLAND 21215-0020 rained by the hospital or attending principal. should be detached folyuse as the point transit titled at once.	ВУ	11. MARITAL STATUS 1 Never Married 2 Merried 3 Wildowed 4 Divorced	12. WAS DECEDENT EVER IN I FORCES? 1 YES IF YES, GIVE WAR OR DAT	2 XNO	If yes, sp	ENDENT OF HISPA ecify Cuban, Mexic 2 ⋈ NO Speci	en, Puerto Rican	14. RACE - Black, 1 Specify:	American Indian, White, etc. White			
MARYLAND 21215-0020 retained by the hospital or attending pre- 5 should be detached for use as the annu- notified at once.	LETED	15. DECEDENT'S ED (Specify only highest grace Elementary/Secondary (0-12)	UCATION (completed) College (1-4 or 5+)	(Give kind of work life. Do NOT use re	done during mo tired.)	ON st of working		O OF BUSINESS/IN		WIIICE		
YLANC by the hosp be detache at once.	COMPL	12th 17. FATHER'S NAME (First, Middle, Last)	Hiliary Matus	Waitres szewski	5			stauran Melden Sumama) Perald	5			
5 5 5	TO BE	190. INFORMANT'S NAME (Type/Print) Bonnie Schirme				nd Number or Rural	Route Number, C	ity or Yown, State, Zi		nd 21206		
BALTIMORE, I ter death. Page 6 may be the funeral director, page yval.		20e. METHOD OF DISPOSITION 1	noval from State cemet MC	ery, cremetory or other	atory,	Inc.						
BALTIMO after death. Page 6 by the funeral direct moval. cal examiner mu		· Osone	3minor	eski-	George 4001	e J. Gon Ritchie	ce Fune	Baltimor	e. Md.			
within 24 hours at within 24 hours at pletely filled in by cremation, or rem rent, the medic		23. PART. Enter the diseases or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or reepiratory street, shock, or heart faffure. Liet only one cause on each line. IMMEDIATE CAUSE (Finel disease or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF):										
P.O. BOX 68' th certificate be execute therefore physician and c all Hygiene prior to buria or other traumatic	CERTIFICATION											
RECORDS, I we requires that the death the been signed by the arter pt. of Health and Mental as shows any injury,	MEDICAL O	PART II. Other algnificant conditio	na contributing to deeth but	not resulting in t	he underlying	ceuse given in		WAS AN AUTOPSY PERFORMED? YES 2 1 NO	AN O	VERE AUTOPSY FINDINGS MALABLE PRIOR TO COMPLETION OF CAUSE OF DEATN?		
AL has thas Dept	SIAN: N	DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26	PLACE OF DEATH (Check only one)	UNCERTAI	N 🗆			YES 2 K NO		
NO OF VITA NG PHYSICIAN: The fifer this certificate leath with the State marked, or Item	PHYSICIAN:	1 YES 2- NO 27. MANNER OF OEATN Return 5 Pending	HOSP!TAL: 1 Inpetient 2 ER/Outpeti 28e. OATE OF INJURY (Month, Day, Year)	lent 3 DOA 4 C	F 28c. INJU	RK?		cfy) E HOW INJURY OC	CURED			
TSTON TTENDING TOR: After after death	ETED BY	2 Accident Investigation 3 Suicide 6 Could not be determined	26e. PLACE OF INJURY — building, etc. (Specify	At home, ferm, atree		ES 2 NO	281. LOCATION City or Tox	(Street end Numbern, Stete)	r or Rural Rou	ite Number,		
L OR L DIRE	COMPLE		ICIAN: To the best of my knowled							and menner on stated.		
TO THE HOSPITA TO THE FUNERA DE filed within 72 IMPORTANT: 11	TO BE C	29b. SIGNATURE AND TITLE OF CERTIFIE	1 Cour		29c. LICENSE NUI	MBER	29d. DAT		fonth, Day, Year)			
	F	30. NAME AND ADDRESS OF PERSON WI	e 5810 Be	lain Mo				•		-		
		DECT 8 1995	34. REGISTRAR'S SIGNAT	URE								

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Data of Death 3. Time of Death Dey **Physician** Daisv Moser 9:55 P.M. 14 1995 Dec. /Medical 4a. Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Brookwood Road Baltimore N/A 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Yaar If Undar 24 Hrs. Birthplaca (State or Foreign Country) 8. Dete of Birth (Month, Day, Year) **Funeral** 1□M 2MF Months Deys Hours 83 Yrs. Director 220-16-3186 Sept. 29, 1912 Maryland Usual Residence of Decedent 10a State 10b County 10c. City. Town or Location 10d. inside City Limits Md. N/A Baltimore 1X Yas 2 No Director 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 704 21229 Brookwood Road U.S.A. Funeral 12. Was Decedent Ever in U,S Armed Forces? Was Decedent of Hispenic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puerto Rican, etc.) 11. Marital Status 14. Rece - American Indian. Black, White, etc. 1 ☐ Yes 2X No If Yes, Giva 1 Never Merried 2 20 Married 21215-0020 6 1 ☐ Yes 2X No Specify: White þ 3 Widowed 4 Divorced Yeer or Detes: Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filled within Hygiene. Elamantary/Secondery (0-12) Collage (1-4or 5+) Registered Nurse Health Care altimore, Maryland 17. Fethar's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Melden Sumeme) or and Mental h Be Charles Myers Esther Stenger Pages 1 and 2 should 19e. informant's Neme/Reietlonship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) entrant of Health Important if item 27 is any injury or other once. Vossburg Moser (Spouse) 704 Brookwood Road Baltimore, Maryland 21229 20b. Piece of Disposition (Name of cemetery, cramatory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burlei 2☐Cremetion 3 ☐Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Dec. 18, 1995 Catonsville, Maryland Metro Crematory 21. Signature of Eugerel Service Licensee 22. Nama and Address of Facility Leroy M & Russell C Witzke Funeral Homes 23a. Pert 1. Egher the diseasa, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, Approximat shock, or haart feilure. List only one ceusa or each line. Approximata Intervei Between Onset and Death Physician Emphysera and regressions falue /Medical immediete Ceuse (Final years diseesa or condition resulting in death) Examiner The law requires that the deeth certificate be executed Sequentially list conditions, if any, leeding to immediate cause. Enier Underlying Ceuse (Disease or injury that initieted events resulting in daath) Last Due to (or es a consequance of): pug Box 68760 Physician/Medical the Due to (or es e consequence of) signed by the ed Records, P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contributa to the cause of death? 1 1 Yes 2 □ No 3 □ Probably 4 □ Unknown þ 24b. Wera autopsy findings available prior to Completed 24a. Wes an autopsy completion of ceuse of deeth? certificate hes lirector, page 2 : 1 Yas 2 No 1 ☐ Yes 2K No Division of Vital Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifics tely filled in by the funeral director, I Be 25. Wes case referred to medical 28. Place of Deeth (Check only one) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) ٩ 1 Yes 2 No 1 ☐ inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28e. Dete of injury (Month, Day Year) Certification: 27. Mennar of Deeth 28b. Time of 28d. Describe how injury occurred 28c. injury at Work? 1 Neturei 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 Suicide 6 Could not be Piece of Injury - At home, ferm, straat, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 4 Homicide 24 hours 1 Certifying Physician: To the best of my knowledga, daath occurred at the time, dete end place, and dua to the cause(s) end manner as steted.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, daath occurred at the time, dete and place, and due to the cause(s) end manner steted. Medical 29e. Certifier within 24 hor To the Fune completely fil 29c. License number 29b. Signeture and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar

OHORIES 31. Dete flied (Month, Dey, Year)

R GANTAN DA MO

The man per office the ses Bank no 428

30. Nema and address of person who completed ceuse of deeth (itam 23e) (Type, Print)

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

Ь	KO			State of M	larylan		rtment tificate			nd Men		giene9 5 Reg. No.	38	3154	
	Physici /Medi Exami	cal	Decedant's Nama (First, Middla, Las WILLIAM Edwart 4e. Facility Nama (If not institution, give	d M	ERRI	TT		4b	. City. Town	- N	ata of De fonth EC.	oth Day	Yaar 995	3. Tima of Death	
	Funeral Director	ier	HOPKINS BAYVIEW 5. Social Security Number 6. So	MEDICA	L CE	NTER	E.R. If Under 1 Months		BA L	TIMOI Hrs. 8. D Min.	RE ata of Bir	h	9. Birthpl	ace (Stata or Foreign try) 1Land	
death with the Maryland	28a-f show notfilled at	ctor	Usual Rasidance of Decedant 10a. Stata 10b. County Maryland Bal	timore	10c. Cify	, Town or Loc	cation	Dun	idalk	-		9 1 1 1		Od. Inside City Limits 1 ☐ Yas ※ No	
th with th	23a or 28	Funeral Director	10e. Street and Number 2524 McComas Ave	nue			10f. Zip C		222				What Country? States		
_ 6	or its	by	11. Maritei Stalus 1 Nevar Married 2 Married 3 Widowed 4 Divorcad	12. Was Deceden Armed Forces 1 ☐ Yas 2 If Yas, Giva Yaar or Datas:	?		/as Deceda Yas, specif		panic Origin , Mexican, F Specify:	n? (Specify) Puarto Ricar	as or No , elc.)	- 14. Ra Bla Specif	ca - Amarica ck, Whita, a y: (
21215-0020	r than "	Be Completed	15. Decedeni's Ed (Specify only highast grad Elamantary/Secondary (0-12)	ucation da completed) Collaga (1-4or	5+)	ant's Usual sind of work O NOT use semble	dona du retired)	ion <i>ring most</i> o	f working		16b. Kind of B		usny Manufactur		
ື ອ	t of Health and Mental Hygis If Itam 27 is marked other or other traumatic event, u	To Be C	17. Father's Nama (First, Middla, Last) William Mirin Me	Name (Fire		Maiden Sumai S	ne)								
	Health and I am 27 is ma other traume		19a. Informani's Name/Raiationship (7 Mrs. Lucila N. N	eta Numbi	or, City or Town MD 212		Code)								
Baltimore,	Department of Health Important: If Itam 27 any Injury or other ti		20a. Mathod of Disposition 1 □ Burial 2 ②Cremation 3 □ 4 □ Donation 5 □ Other (Spacify	2/14/		Towso									
Ball	Depart Import any in		21. Signature of Fundai Service Licens	12:	/ /	1	Duda - R	uch	Funon	ial Ho	mo o	6 Dunda	lk, II	nc.	
5 1	nysician Medical xaminer	ner	23a. Part1. Entar tha disaasa, or comp shock, or haart fallure. List only of Immediata Cause (Final disease or condition rasulting in death)	a. ATH	nosc		nc c						Se	Approximate Interval Between Onset and Death	
Box 68760, death certificate be executed	nding physician and use as the burial-transit	n/Medical Examiner	Sequantially list conditions, if eny, leading to immediate causa. Enter Underlying Cause (Disease or Injury that initiated evants resulting in death) Lest	cd.		as a consequ									
P.O. B	ach th	Physician/M	Part II. Other significant conditions co	nIributing to death I	out not rasu	Iting In the un	darlying cau	isa givan	in Part I.			robacco use co	ntribute to	the cause of death?	
Records, P.O	been sign should be	Completed by P									4a. Was	an eutopsy med?	24b. Wa	re autopsy findings liabla prior to npletion of cause laath?	
= F	certificate has rector, page 2		25. Was casa refarred to medical						00.00	ID - 11 (2)		as 2 No		Yas 2 No	
in of	fter this uneral di	ation: To Be	examinar?	Hospital: 1 Inpati 28a. Date of Inj (Month, Da	444	R/Outpatiant 28b. Tima of Injury		Other: : Injury a Work?	4 ☐ Nursi	28d. [5 ☐ Rasid	iance 8 Oth)	
Division	within 24 hours after death. To the Funeral Director: After completely filled in by the funeral compl	Certification:	3 Sulcida 6 Could not be 4 Homicida datamined	28a. Place of In building, a	jury - At hor ic. (Specify)	ma, ferm, stre	el, factory, o	offica			ocation (Sity or Tox	Street and Numi m, Stata)	oer or Rural	Routa Number,	
Ithe Hospital	tin 24 hou the Funer pletely fil	ledical	29a. Cartifiar (Check only one) 1 ☐ Certifying Phy 2 ☐ Certifying Phy 2 ☐ Certifying Phy (Check only one)	sician: To the best ner: On the basis of end mannar si	f axaminati	viedga, daath o on end/or Inva	astigation, in	my opin	nion, deeth	olace, and di occurred at	ua Io tha Iha Iime,	causa(s) and madeta and placa,	annar as sta and due to	ated. tha cause(s)	
E A	To To	Σ	29b. Signature and title of certifier 30. Nama and addrass of person who co	elfheel	leath /learn	23a) /Tuna D	0	. C .				29d. Date signe DECEMB			
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	Registr		DEC 1 8 1995	- Level or	Rardall										

DEC 1 8 1995

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 5 Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Time f th Month December 17,1995 Louis Joseph McLain 6:57A.M 4a. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Meridian Hamilton Nursing Home Baltimore 5. Social Security Number If Undar 1 Yaar If Undar 24 Hrs. 7. Aga (In yrs. last birthday) Birthplaca (Stata or Foraign Country) 1**X** M 2□ F Days 80 216-01-6640 Yrs. June 4,1915 Maryland Usuai Rasidance of Dacedant 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 X Yas 2 No N/A Maryland Baltimore 10g. Citizan of What Country? 10e. Street and Number 10f. Zip Coda 4001 Century Road 21206 United States 12. Was Decedant Evar in U.S. Armed Forcas? 1 ☐ Yas 2 ☑ No If Yas, Giva Yaar or Datas: Was Decedant of Hispanic Origin? (Specify Yas or No-if Yas, specify Cuban, Maxican, Puarto Rican, atc.) Race - Amarican Indian Biack, Whita, atc. 1 Navar Married 2 Married 1 ☐ Yas 2 X No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedant's Education (Specify only highast grada complated) 16a. Decedent's Usuai Occupation 16b. Kind of Businass/Industry (Giva kind of work dona during most of working lifa. DO NOT usa retired) Eiamantary/Secondary (0-12) College (1-4or 5+) Car Care 6th Grade Attendant 17. Fathar's Name (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumema) Alfred McLain Evelyn Unknown Littleston 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Coda) 4001 Century Road Baltimore, MAryland-21206 Martha Ellen McLain 20b. Placa of Disposition (Nama of comatary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 ☐ Buriai 2 ☐ Cramation 3 ☐ Ramovai from Stata 12 - 194 ☐ Donetion 5 ☐ Othar (Spacify) Hilltop SErvice Corp. Towson, Maryland 21. Signatura of Funaral Sarvice Licenses 22. Nama and Addrass of Facility 6415 Belair Road John C. Miller, Inc. Baltimo

23a. Part Enter the disease, or complications that caused the disease of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. John C. Miller, Inc. Baltimore, Maryland-21206 Approximata interval Batween Onsat and Death Obstructive Lung Disperse immediata Ceusa (Finel FARS disaasa or condition rasulting in death) Sequentially list conditions, if any, leading to immadiate causa. Entar Undarlying Cause (Disease or injury that initiated avants rasulting in death) Last Dua to (or as a consequence of): Dua to (or as a consequenca of) Part II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 No 3 Probably 4 Unknown EREBROVIKCULAR ACCIDEA 24b. Ware autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 1 No 1 Yas 2 No 1 Yas 25. Wes casa rafarred to madical 26. Placa of Deeth (Check only ona) Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa 5 Rasidenca 8 Othar (Specify) 1 Yas 2 No 28c. injury at Work? 27. Menner of Death 28a. Dete of injury (Month, Dey Year) 28b. Time of 28d. Dascribe how Injury occurred 5 Pending investigation Injury 1 Yas 2 No 6 Couid not be determined Piaca of Injury - At homa, farm, streat, factory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Steta) Certifying Physician: To tha best of my knowledge, death occurred at the tima, data and place, and due to the cause(s) end manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) end manner stated. 29b. Signatura and titla of cartifiar 29c. Licansa number 29d. Data signed (Month, Day, Year)

deeth with the Meryland permit. Pages 1 and 2 should be filed within 72 hours efter deeth with the Merylan Department of Health and Mental Hygiene. Important: If time 27 is marked other than "netural", or items 23a or 28a-f show any injury or other traumatic avant, me Medical Exammer mast be normed any injury or other traumatic avant, me Medical Exammer mast be normed. Baltimore, Maryland 21215-0020 Physician /Medical **Examiner**

Physician

/Medical

Examiner

10a. Stata

11. Marital Status

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1 Naturai

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Funeral

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signed by the ettending physician and I be detached for use as the buriel-transit The lew requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, peeu certificate hes To the Hospital or Attending Physician: within 24 hours effer death.

To the Funeral Director: After this certifica completely filled in by the funeral director, t

Registrar

Joseph B. Kligman 31. Data filed (Month, Day, Year) DEC 1 8 1995

Vos. KUGMAN, MD.

5901 Harford Road Baltimore, Maryland -21214 32. Registrar's Signatura in Shoul or hardall

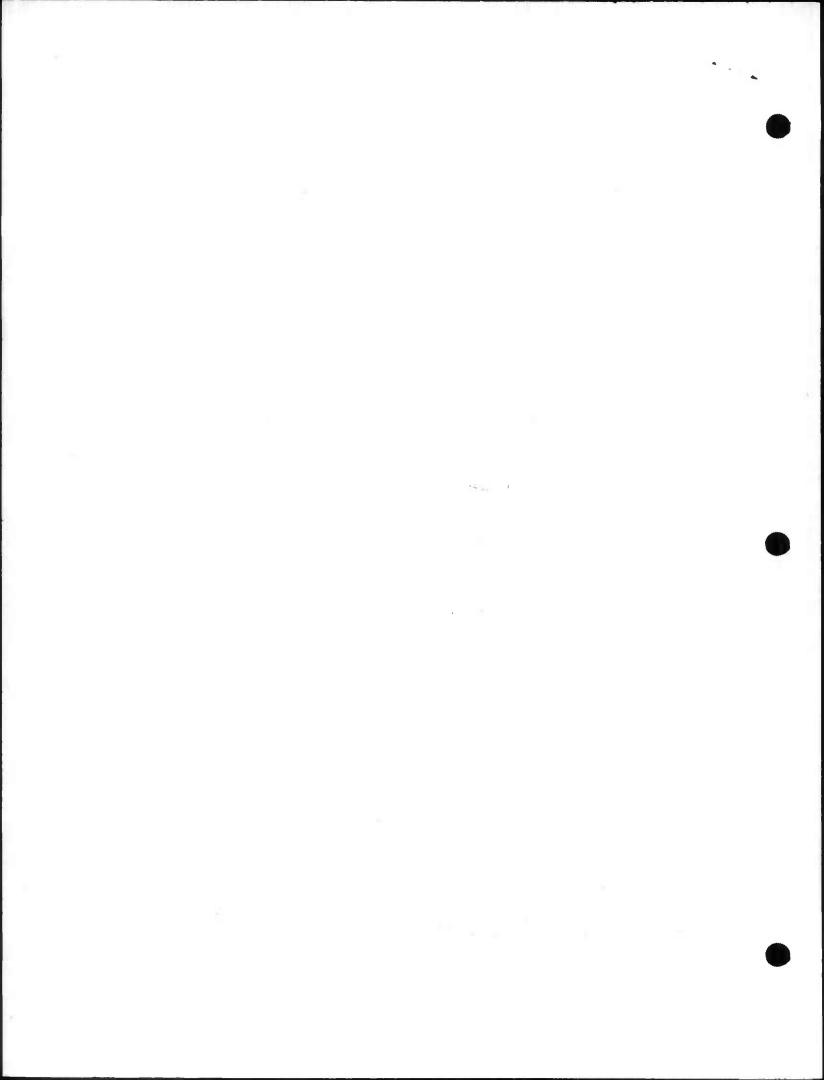
30. Nama and addrass of person who complated causa of death (Nem 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

				State of	Marylar		artment tificate			ınd M	lental Hy	/gier Reg. 1		3 (312	0
	Dhusial		1. Decedant's Nama (First, Middla, La	st)							2. Data of D	aath)av	Vaar	3. Time	of Death
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•	Examir		4a. Facility Nama (If not institution, give	a street and numi	oer)			4b	c. City, Tov	wn, or Lo	cation of Dea	th 4	4c. County	of Death		
			4809 Althea Aven						altim	pre	City		N/A			
	Funeral		5. Social Security Number 6. S	Sax 7.		last birthday) Yrs.	If Undar 1	Days	If Undar 2 Hours	Min.	8. Data of Bi (Month, D Dec.	irth ay, Yea	Tana P	Coun	(nv)	ta or Foreign
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	r 28a-f show	Director	10e. Straat and Number				10f. Zip C	oda				10g. 0	Citizan of V	Vhat Coun	try?	
	3a o	Die	4809 Althea Avenu	е			21	206					J.S.A.			
	n 72 hours elter deeth with the Maryland "natural", or items 23a or 28a-f ahow adical Examinet mast be recitied at	Funerai	11. Marital Status	12. Was Daced			Vas Dacedar	nt of His	panic Orig	jin? (Spe	cify Yas or N	0-		a - Amaric		,
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Ĕ	f or Attending leiter deeth. Director: After 1 in by the funa	Certification:	3 ☐ Sulcida 6 ☐ Could not b 4 ☐ Homicida datamined	Zoa. Place of	Injury - At h	oma, farm, stre	eat, factory, o	ffice		2	28f. Location City or To	(Street own, Sta	and Numb ata)	er or Rura	Routa N	lumber,
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	To the Hospital or Attending Physician: The Is within 24 bours either death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	edical	29a. Cartifiar 1 Certifying Ph (Check only 2 Madical Examone)	iner: On the basi	s of axamina	wladga, daath tion and/or Inv	occurrad at a	tha tima my opi	a, data and Inion, daati	i placa, a h occurre	and dua to the ed at tha time	a causa , data a	(s) and ma and place, a	nner as st and dua to	ated. tha caus	a(s)
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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hosy	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detache	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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	1 - FOR STATE REGISTRAR		STATE OF I		O / DEPAI					MENT	NL HYGIEN			
	1. DECEDENT'S NAME (First	W.	Penla 5. SEX	and						D	c /-	ñ (95	3. TIME OF DEATH Q 15 PM
	221-03-154		1 M 2 X F	6. AGE (In yrs	. last birthday)	MONTHS	DAYS	HOURS	MIN.	(Moi	OF BIRTH (th, Day, Year)	911	8. BIRTN Countr	PLACE (State or Foreign y) MD
_		In. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH											EATH	
TOT.	MD Howard Columbia													
DIRECTOR												10d. INSIDE CITY LIMITS? 1 Tyes 2 X NO		
FUNERAL												VHAT COUNTRY?		
ВУ	1 Never Married 2 Married FORCES? 1 YES 2 X NO If yes, specify Cuban, Mexican, Puerto Ricen, etc.) Black, W?										- American Indian, c, White, etc.			
TED	15. DEC (Specify onl	EDENT'S EDUC ly highest grade	ATION completed)	16a	Give kind of	Work done	CCUPATIO during mo	ON ast of worki	ng	16	b. KINO OF BU	SINESS/INC		
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ш	Joseph C.		ley								Middle, Meider 11ins	Surname)		
TO B	19a. INFORMANT'S NAME (nber, City or Tov			MD 21042
	Ron J. You		epnew)	20h BLA										MD 21042
	20s. METNOD OF DISPOSITION 1											MD		
	22. NAME AND ADDRESS OF FACILITY Leroy M & Russell C Witzke Funeral													
	The second secon	aucc		te		55	55 7	Win	Kno.	lls	Rd. Co	lumbi	a, M	ID 21045
	ahock, or heart failure. List only one cause on each line.											Approximata Interval Batween Onset and Death		
CERTIFICATION	If any, leading to imme cause. Enter UNDERLY CAUSE (Disease or Inju that initiated events	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that Initiated eventa resulting in death) LAST b. Jroke DUE TO (OR AS A CONSEQUENCE OF): c. SID Colectory DUE TO (OR AS A CONSEQUENCE OF): d. And Fib.												
MEDICAL C	PART II. Other algnifica								given in	Part I.	24s. WAS AF PERFO 1 TYES	RMEO?	24b	WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATN? 1 YES 2 NO
AN:	DID TOBACCO U		RIBUTE TO CA		EATH Y			UNC	CERTAI	N 🗹				
SICIAN:	EXAMINER?	O MEDICAL	HOSPITAL:			OTHE	B:	e 5 🗆 R	esidence	6 Ott	er (Specify)			
ЬΗΥ	27. MANNER OF DEATN		26a. DATE OF	FINJURY	26b. Til		2Sc. IN.	URY AT		_	ESCRIBE NOW	INJURY OC	CURED	
ВҰ	2 Accident	Pending Investigation	28a PLACE (OF INJURY — A	it home form	M mirrort for		YES 2 [NO	204.16	CATION (Street	and Mumba	on Burnt	David Manufacture
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COMPLET	000)		CIAN: To the best of a											i) and manner as stated.
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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The Jaw requires that the death certificate be executed within 24 hours after death. Page 6	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral directs	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner mu
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1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH 1995 2:00 A.M. MELVIN W. PRUETT DEC. 15, 7. DATE OF BIRTH (Month, Day, Yber) OCT. 22,1916 8. BIRTHPLACE (State or Foreign A SOCIAL SECURITY NUMBER 5. SEX 8. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. DAYS HOURS MISSOURI 491-09-0519 1 💢 M 2 🗌 F 79 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH NORTH ARUNDEL HOSPITAL GLEN BURNIE ANNE ARUNDEL DIRECTOR RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10a. STATE 10d. INSIDE CITY LIMITS? MARYLAND ANNE ARUNDEL GLEN BURNIE 1 YES 2 X NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? UNITED STATES 21061 314 JOHNSONS FARM RD. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FDRCES? 1 XYES 2 ND IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, White, etc. If yes, specify Cuban, Mexican, Puerto Rican, etc.)

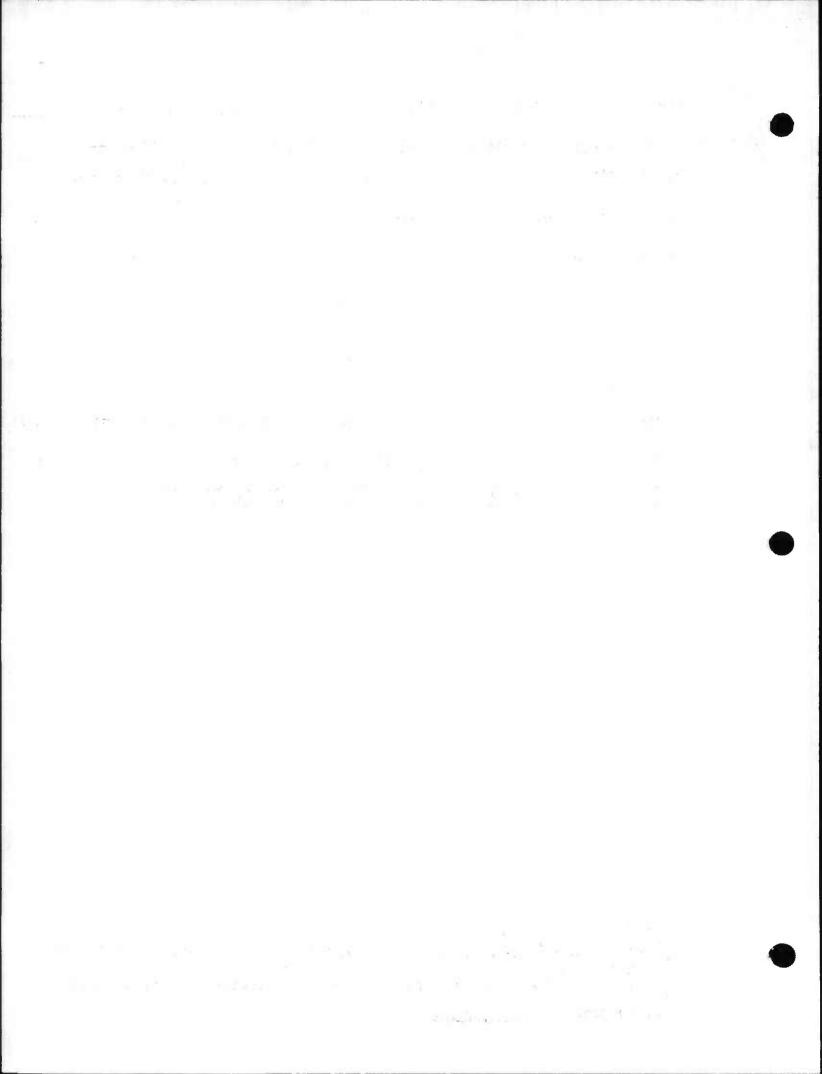
1 YES 2 NO Specify: 1 Never Married : 2 X Married Specify: BY 3 Widowed 4 Divorced WHITE WW II COMPLETED 15. DECEDENT'S EDUCATION 16s. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only highe Elementary/Secondary (0-12) College (1-4 or 5+) ARTIST ARTISAN 8 17 FATHER'S NAME (First Middle Leat) 18. MOTHER'S NAME (First, Middle, Maiden Surname) OLLIE SHERWOOD HARRY PRUETT 19a, INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 314 JOHNSONS FARM RD., GLEN BURNIE, MD 21061 ELIZABETH E. PRUETT 206. PLACE AND DATE OF DISPOSITION (Name of DEC. 15pate 20a. METHOD OF DISPOSITION .
1 □ Burlal 2 💢 Cremation 3 □ Removal from State 20c. LOCATION - City or Town, State 1 Donation METRO CREMATORY, INC. CATONSVILLE, MARYLAND 1995 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE DICENSEE 22. NAME AND ADDRESS OF FACILITY KIRKLEY-RUDDICK FUNERAL HOME 421 CRAIN HWY., S.E., GLEN BURNIE, MD 21061 23. PART I. Enter the diseases, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death IMMEDIATE CAUSE (Final disease or condition___ CERSARO VASCULAR tours resulting in death) DUE TO (OR AS A CONSEDUENCE DF) YEARS THEROSCLENOTE CERTIFICATION Sequentially list conditions, If any, leading to immediate cause. Enter UNDERLYING FEBRELLE CAUSE (Diseese or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other algorificant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS MEDICAL HISTORY OF MULTIPLE GREBRAMS CHIMS ACCESSIONS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 TYES 2 X NO APNEA DYS FUNCTION -1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES & NO UNCERTAIN PHYSICIAN: HOSPITAL: PLACE OF DEATH (Check only one) 25. WAS CASE REFERRED TO MEDICAL 1 TYES 2 XND et 2 ER/Outpetlant 3 🗆 DOA 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify) 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 28d. DEŞCRIBE HOW INJURY OCCURED 1 XNatural 1 YES 2 ND BY 2 Accident 28a. PLACE DF INJURY — At homa, farm, atreet, factory, office building, etc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Sulcide COMPLETED 4 Homicide determined 1 XX CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and menner as stated. 2 MEDICAL EXAMINER: On the besis of exemination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(e) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d, DATE SIGNED (Month, Day, Year) **BE** 2 30. NAME AND ADDRESS OF PERSON WHD COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 500 200 HOS PATTAL 32. MEGISTRAR'S SIGNATURE 21061

DHMH-18 Rev 1/89

Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible.

28159 State of Maryland / Department of Health and Mental Hygiene Q 5

										Death	Wichtarry	Reg. No.	0 0	0133
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	Exami		4a. Facility Nama (If r	not institution, giva	streat and numbar)			- '	4b. City, Town, or	Location of Deal	h 4c. County	of Death	
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	Funeral Director		5. Social Security Nur 215 45 844	14	X XM 2□F	ge (In yrs. Ie	Ast birthday) Yrs.		Days	Hours Mir	. (Month, D	th 16,1995		ca (Stata or Foraign r) and
	pue Ax		Usuat Rasidence of D	10b. County	-	10c. City	, Town or Loc	ation					100	I. Insida City Limits
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ore,			20a. Method of Dispo			20b. Pla	ace of Dispos matary, crami	ition (Nam	a of har plac	> 8)	Data	20c. Location	- City or Town	n, Stata
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Baltimore,	permit. Pege Depertment of Important: If any injury or once.		21. Signatura of Funa	arai Sarvica Licens	96	-					ral Home		7.04	204
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on	ding h. After fune	tlon	Naturel	5 Pending invastigation	28a. Date of Inj. (Month, Di	y Year)	28b. Time of injury	M	Sc. injur Wor	yat k? Yas 2 □ No	Zod. Dascribe	how Injury occur	160	
Division	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune.	Certification:	Image: Accident 3 ☐ Suicida 4 ☐ Homicide 6 ☐ Could not be determined 28a. Place of injury - At homa, farm, streat, factory, office building, afc. (Specify)											
	To the Mospital or within 24 hours after To the Funeral Dir completely filled in	edical Ce	(Check only 2	☐ Certifying Phys										
	the I	Med	one)	Λ	and manner s	ated.				a number				
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	1		30. Mamo and polys	of person who co	mpleted cause of	111			eet	, Balt	imore,	Maryla	nd 21	201
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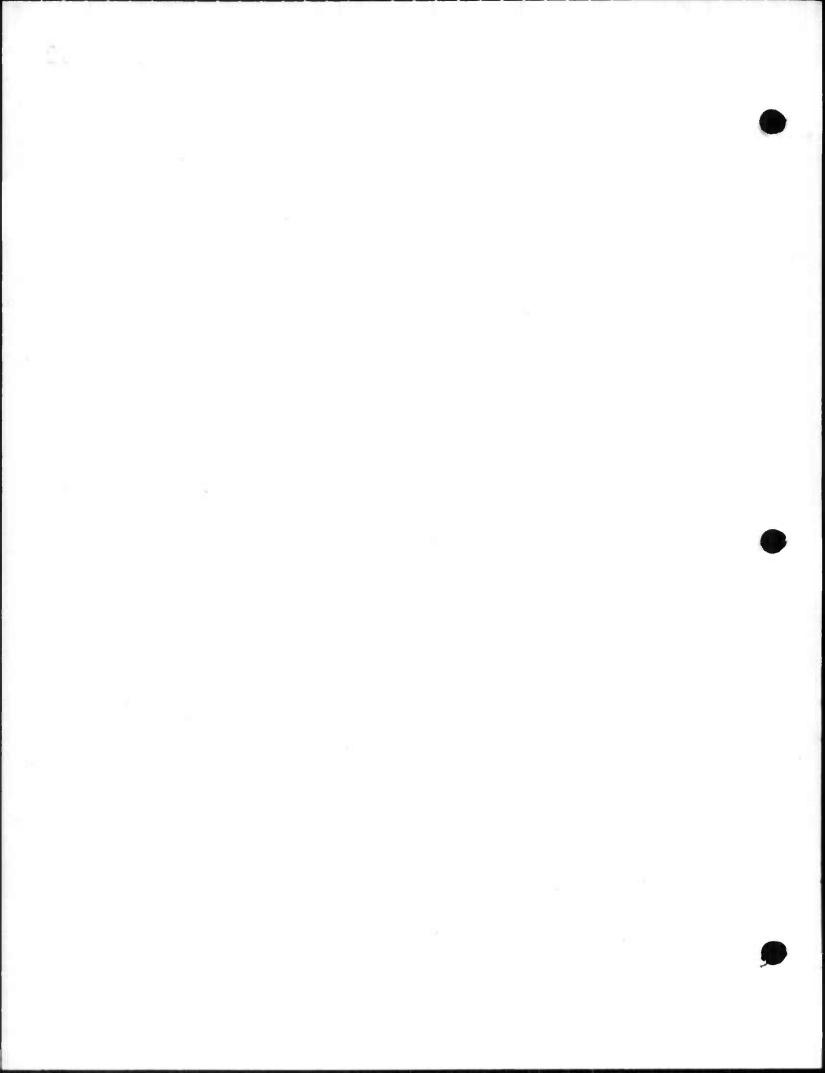
BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

1 - STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

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		1. DECEDENT'S NAME (First, Middle, La. Donald Renner	st)							MONTH	F DEATH DA		YEAR	TIME OF DEATH	
		4. SOCIAL SECURITY NUMBER	5. SEX	6 AGE (In	yrs. last bir	tholon) s	UNDER 1 YE	n E mo	ER 24 MRS.					4:00 P M	
		214-40-0352	1 M 2 □ F	or rear (iii	53		NTHS DA		7	Feb.	1942	2	Maryla	and	
5		9e. FACILITY NAME (If not institution, given	e street and number)			9b.	CITY, TO	N OR LOCA	TION OF D				NTY OF DEAT		
200000000000000000000000000000000000000	DIRECTOR	275 Montrose Av		E	ssex					Bal	timore	9			
	EC	10a. STATE 10b. COU			1	Oc. CITY, TO	OWN OR LO	CATION					10	d. INSIDE CITY	
	DIR	Maryland Bal	timore			E	ssex						100	LIMITS?	
	IAL	10e. STREET AND NUMBER				10f. ZIP CO	DE			10g. CITI	ZEN OF WHA	T COUNTRY?			
	FUNERAL	275 Montrose Ave							221				U.S.A.		
- 100		11. MARITAL STATUS 1 Never Married 2 Married	12. WAS DECEDENT FORCES? 1	YES	2 NO)	13. WAS	DECENDENT , specify Cut	OF HISPAI	NIC ORIGIN? in, Puerto Ri	(Specify Yes	or No-		American Indian, hite, etc.	
	В	3 Widowed 4 Divorced	1962-196		ES		1 🗆	YES 2 R NO	Specif	у.		ĺ	Specify:	White	
	COMPLETED	15. DECEDENT'S E (Specify only highest gri	DUCATION			ENT'S USU		ATION most of work	kina	16b.	KIND OF BUS	SINESS/IND			
		Elementary/Secondary (0-12)	College (1-4 or 5+		life. Do	NOT use ret	tired.)		ung						
once.	NE NE	17. FATHER'S NAME (First, Middle, Last)			Serv	ıce T	'echn	ician					ir Cor	nd. Co.	
To		Donald E. Renn	er						elyn		ddle, Meiden . Villia				
notified	TO BE	19e. INFORMANT'S NAME (Type/Print)						et end Numb	er or Rural	Route Numbe	r, City or Town	n, State, Zip	Code)		
be no	F	Anna Lee Renner			27!	5 Mon	tros	e Av.	Balt	imore	e, Mar	ylan	d 2122	21	
must		20a. METHOD OF DISPOSITION 1 Buriel 2 Cremetion 3 Re	emoval from State	20b. P	PLACE AND	DATE OF DI	ISPOSITION	tory	12/1	DATE	20c. LO		imore, Maryland		
		4 ☐ Donation 5 ☐ Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE.	LICENSEE	Gre	enmo	unt C		COLA ADDE			Ватт	lmor	e, Mar	ryLand	
examiner		Bruzdzinski Funeral Home P.A.										-			
		23. PART i. Enter the diseasea, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Returned													
medical		shock, or neart failur	e. List only one caus	se on eac	h line.	. 50 1101 4	orner the	mode or d	ying, auc	n aa carol	nc or reapn	ratory arr	est,	Interval Between	
nie.	j	iMMEDIATE CAUSE (Final disease or condition resulting in death)	is									Onset and Death			
event,		readiting in death)			ONSEQUE	NCE OF):									
ח חוופו הפחוופוור	NO	Sequentielly ilat conditions, DUE TO (OR AS A CONSEQUENCE OF):													
1000	CERTIFICATION	if any, leading to immediate cause. Enter UNDERLYING	502 10 (On AS A C	ONSEGUE	NCE OF):									
	Ē	CAUSE (Disease or Injury thet initiated events	DUE TO (OR AS A C	ONSEQUE	NCE OF):									
	ERI	resulting in death) LAST													
amy injury,		PART II. Other aignificant conditi	ona contributing to	deeth but	not resu	iting in th	ne underi	/ing cause	given in	Part I.	24s. WAS AN			RE AUTOPSY FINDINGS	
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shows	ME													YES 2 NO	
23 8	N.	DID TOBACCO USE CON	TRIBUTE TO CAL		_				CERTAI	N 🔯					
IMPORTANT: If item 28 is marked, or item 23 show	PHYSICIAN	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO	HOSPITAL:				HER:				3 8.				
0	HYS	27. MANNER OF DEATH	1 Inpatient 2 I			b. TIME OF		INJURY AT	Residence		Specify)	LIURY OCC	CURED		
arke	ву Р	1 Natural 5 Pending 2 Accident Investigation	(Month, Day	y, Ybar)		INJURY		WORK?	□ NO						
E		3 Suicide 8 Could not b	28e PLACE OF	INJURY -	At home,	farm, street	t, tectory, o	ffice		28t. LOCAT	TON (Street e. Town, State)	nd Number	or Rural Route	Number,	
97 E	ETE	4 Homicide determined								O., O.	ionn, orany				
	COMPLET		SICIAN: To the best of r												
NA II	00	2º MEDICAL EXAMI	NER: On the basis of ex	mination e	end/or Inves	rtigation, in	my opinio	n, death occu	ared at the	time, date e	nd place, end	d due to th	e cause(e) an	d manner ee stated,	
	BE	296, SIGNATURE AND TYTLE OF CERTIF	IEB B C C	97	111			29c. LIC	ENSE NUN	IBER		29d. DATE	SIGNED (MI	TOT	
1	유	30. NAME AND ADDRESS OF PERSON'S	THO COMPLETED CAUSE	OF DEAT	H (ITEM 27) (Type, Print	()	$\mathcal{L}\mathcal{V}$.	LYI	77		- /	413	175	
		Dorothy Snow, M.	D., 10 N.	Gree	ne St			ltimo	re, M	laryla	and 2	1201	/ /		
		31. DATE FILED (Month, Day, Year)	THE REGISTRAN	BISM I	P E										
- 1		DEC 1 8 1995													





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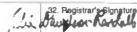
95-76	19-	210		State	of Maryla	and / Dep <i>Ce</i>	artment d rtificate			d Ment			5 3	8 6	
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6 -1	miner	4a. Facility Name (If n	ot institution, gi	va street and nu	umber)			4	b. City, Town,	, or Location	of Death	4c. County	of Death		
		600 s.	SMALL	WOOD S	ЗΤ.				BALT	IMORE	7.	BALTI	MORE	CITY	
Fune Direc		5. Social Security Num 217-38-370	nber 6.	Sex 1⊠M 2□F		rs. last birthday) Yrs.	if Under 1 Y Months D	raar ays	If Under 24	Hrs. 8. De Min. (M	ta of Birth conth, Day, CH 8,		9. Birthple Count MARY	aca (State or Fo	oreign
2 .		Usual Residence of D													
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ith the M or 28s-f	l ë	10e. Street and Numb	97				10f. Zip Co	da			10	g. Citizen of V	Vhst Count	ry?	
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Un after death with air, or items 23e or	by Funeral			Armad F 1 ☐ Yas If Yas, G	2 X No iva		Was Decedant If Yas, specify 1 ☐ Yes 2 ☑	Cuba	Ispanic Origini n, Maxican, P Specify:	? (Specify Y uerto Rican,	es or No- atc.)	14. Rec	e - America k, Whita, a	tc.	
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Tany 2 sho and 3 is ma		19a. informant's Nem	e/Ralationship	(Type, Print)		19b. Malli	ng Addrass (S	treet	and Number o	r Rural Rout	e Number,	City or Town,	Stete, Zip	Code)	
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altum nit. Pa antmen ortant: inlury		21. Signature of Femo	-	•	A		2. Name end A			12/1	0	DALITIN	JKE		
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Examin	_	disaasa or condition rasuiting in daath)	iai	a Arte	erios	clerot	ic Car	di	.ovasc	ular	Dise	ease			
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COTGS, P v requires that been signed b should be deta	Completed									2	4a. Wes en perform	eutopsy led?	con	re autopsy findi lable prior to apletion of caus	
The law ate hes t	Comp]		ECTION 25x		eeth? Yes 2□ No	
VITAL I	Be	25. Was casa rafarred axaminar?	to medical						26. Placa of	Death (Che	ck only one)			
OT VITE Physician: this certific ral director,	10	1 □XYas 2 □ No		Hospital:	Inpatiant 2	☐ ER/Outpatier	t 3 DOA	Oth	ar: 4 Nursir	ng Homa 5	KRasider	nce 6 DOth	er (Specify)		
Ing Affer		27. Mannar of Death To Neturel 2 \(\text{Accident} \)	5 Pending Invastigatio		of injury hth, Day Year)	28b. Time o injury		Injury Work	rat ⟨? Yas 2 □ No	28d. D	escribe hov	w injury occurr	ed		
5 6 6 5	ertification:		6 Could not be determined	28a. Place	e of Injury - At ling, etc. (Spe	t homa, farm, str cify)	aat, factory, of	fice		28f. Lo	cation (Stre ty or Town,	eat and Numb Steta)	er or Rural	Route Number,	
pital ours e	0	29a, Certifier 1	Certifying Pt	velclen: To the	heet of my k	noudadaa daatt	annurred at th	ha ilaa	a data and al	lana and du	- 4- 4h	(a) and ma		And .	

Description of the basis of examiner: On the basis of examinetion and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) and manner stated. 29c. License number 29d. Data signed (Month, Day, Year) O.C.M.E. DEC. 15, 1995

30. Name and address of person who completed cause of death (tem 23a) (Type, Print)

Mario F. Golle Jr. M.D. 111 Penn Street, Baltimore, Maryland 21201 31. Data filed (Month, Day, Year)
DEC 1 8 1995

State Registrar



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State of Manyland / Department of Health and Mental Hygiene 95 38 162

Ab. Facility Nama (If not institution, give street and number) Ab. City, Town, or Location of Deeth Ac. County of Death	/Medic Examin Funeral Pirector	al	Melvin John	ist)									
Melvin John Selections of the Prince of the	/Medic Examin Funeral Pirector	al	*****					Month	Day				
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Type Type	retu	etec	15. Decedant's E (Specify only highast gr	ducetion ada complated)	16a. Deced (Giva k	anf's Usual Occup	pation during most of work	king	16b. Kind of Bu	usinass/Indu	stry		
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Coronary artery disease Coronary artery	E etto			20	b. Plece of Dispos	sition (Nama of satory or other place	ce)	Data	20c. Location -	City or Tow	n, Stete		
23a Part Life fire disease, or complications that believed the death. Do not arried the mode of dying, such as cerdiac or respiretory arrest. Approximate trailura. List only one cause on each line.	ury or			JHamovai from Stata			10 1	9-95	Eastwoo	d,Md.			
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24a. Was an autopsy performed? 24b. Wara autopsy finding available prior to completion of cause of death? 1 Yas 2 XNo	for u	clar	Don't I. Other plantificant and distance		ht - lan			oot pitti		1			
24a. Was an autopsy finding available prior to completion of cause of death? 1 Yas 2 No 1 Yas 2 No 1 Yas 2 No 1 Yas 2 No 25. Was cess referred to medical examiner? 1 Yas 2 No 26. Place of Death (Check only one) 27. Mannar of Death 1. Yas 2 No 28. Deat of lipury (Month, Day Year) 28. Deat of lipury (Month, Day Year) 29a. Ceptifier (Cleckonly 2 Medical Examiner) 29b. Signeture and fittle of certilier (Specify) 29c. Licanse number 29c. Licanse number 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year)	ned by the e detached		Part II. Other eignmeant conditions (/en in Part I.									
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25. Was cease referred to medical examiner? 1	pege	S						1 🗆 Y	as 25kNo	10	Yas 2□ No		
The state of the s	entific ector.	Be						th (Check only o	ne)				
29a. Certifying Physician: To the best of my knowledge, death occurred at the fime, data and place, and due to the ceuse(s) and manner as stated. 29a. Certifying Physician: To the best of my knowledge, death occurred at the fime, data and place, and due to the ceuse(s) and manner as stated. 29b. Signeture and tritle of certifior 29c. Licanse number 29d. Date signed (Month, Dey, Year) 29d. Date signed (Month, Dey, Year) 29d. Date signed (Month, Dey, Year) 29d. Date signed (Month, Dey, Year) 29d. Date signed (Month, Dey, Year) 29d. Date signed (Month, Dey, Year) 29d. Date signed (Month, Dey, Year) 29d. Date signed (Month, Dey, Year) 29d. Date signed (Month, Dey, Year)	. O			1 Li Inpatient		3LI DOA	4 Li Nursing n						
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D42083 December 14,1995 30. Nema and addrass of person who completed cause of deeth (Item 23e) (Typa, Print)	filled in by	O	4 Homicida datamined	building, atc. (Specify) City or Town, Sta							ara)		
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D42083 December 14,1995 30. Nema and addrass of person who completed cause of deeth (Item 23e) (Typa, Print)	Zomp	M	29b. Signeture and fittle of certifier			29c. Licans	e number		29d. Date signe	d (Month, De	sy, Year)		
30. Nema and addrass of person who completed cause of deeth (Item 23e) (Typa, Print)	3		▶ /\\ / / / /	A		D4208	3		Decembe	r 14,1	1995		

Registrar

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BALTIMORE, MARYLAND 21215-0020	hours after death. Page 6 may be retained by the hospital or attending physician.	In by the funeral director, page 5 should be detached for use as the burial-transi or removal.	medical examiner must be notified at once.
DIVISION OF VITAL RECORDS, P.O. BOX 68760.	TO THE HOSPITAL DR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	10 THE FUNEKAL UNEXCLUR: After this cartincare has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transi be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or remoral.	IMPORTANT: It Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	1 - STATE REGISTRAR	STATE OF MARYLAND	D / DEPARTM			MENTAL HYGII					
	1. DECEDENT'S NAME (First, Middle, Lest)					2. DATE OF OEATH			. TIME OF DEATH		
	ELIZAbeTH	ア ・	Koe	,		December	14 1	YEAR 1995	1.33 A M		
	4. SOCIAL SECURITY NUMBER 5.	. SEX 6. AGE (In yrs.	. last birthday)IF U	NDER t YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH		8. BIRTHPI	LACE (State or Foreign		
	212-12-4612	□ M 2 1 F 7	7 YRS. MONT	THE DAYS	HOURS MIN.	(Month, Day, Year SEPT. 18		MARY	TAND		
	9e. FACILITY NAME (If not institution, give street	and number)	9b.	CITY, TOWN OF	LOCATION OF O			NTY OF DEA			
DIRECTOR	NORTH ARUND	OFL HOSP	ITAL G	TAL Glen BURNIE					RundeL		
, iii	10e. STATE 10b. COUNTY		10c. CITY, TO	10c. CITY, TOWN OR LOCATION				1	Od. INSIDE CITY		
	MARYLAND ANNE AF	RUNDEL	PA	SADENA				1	LIMITS?		
AL	10e. STREET AND NUMBER			101. ZIP CODE				10g. CITIZEN OF WHAT COUNTRY?			
E	673 209TH STREET				21122		IINT	TED S	שאיייביכ		
FUNERAL		ARMED 13. WAS DECENDENT OF HISPA			NIC ORIGIN? (Specify	Yes or No-					
7	1 Never Merried 2 Merried	Йио	If yes, spec	Ify Cuban, Mexica	an, Puerto Rican, etc.)		Black, 1 Specify:	- American Indian, White, etc.			
ВУ	3 🔀 Widowed 4 🗌 Divorced				gg spoon			эрвену.	WHITE		
COMPLETED	15. DECEDENT'S EDUCATE (Specify only highest grade com	ION 16a.	Give kind of work of	L OCCUPATION	of working	16b. KIND OF	BUSINESS/IND	USTRY			
		College (1-4 or 5+)	life. Do NOT use retir	ed.)	or working						
<u>¥</u>	10		HOMEMAKI	ER			OWN HOL	ME			
8	17. FATHER'S NAME (First, Middle, Lest)			18. MOTHER'S NAME (First, Middle, Melden							
BE	CLINTON PARROTT				LIDA E	EVANS					
6	19e. INFORMANT'S NAME (Type/Print)		196. MAILING ADD	RESS (Street end	Number or Rural	Route Number, City or	lown, State, Zip	Code)			
-	CHARLES R. ROE		1104 O	AKWOOD	ROAD GI	EN BURNIE	E, MD	21061			
	20e. METHOD OF DISPOSITION 1 X Buriel 2 Cremetion 3 Removal		CE AND DATE OF DIS		e of	DATE 20c.	LOCATION —	City or Town	n, State		
	4 Donation 5 Other (Specify)	GLEN	N HAVEN N	ÆM PK.	DEC. 1	5, 1995	GLEN I	BURNI	E, MD		
- 1	21. SIGNATURE OF FUNERAL SERVICE LICENS	EE /			ADDRESS OF FA		-				
	aru L	Chaugh	/			CK FUNERA			MD 21061		
ATION	23. PART I. Enter the diseases, or complications that quiring the death. Do not enter the mode of dying, such as cardiac or reapiratory arrest, shock, or heart failure. List only one cause are ach line. Approximate interval Batween Onset and Death Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING Due to (or as a consequence of):										
CERTIFICATION	CAUSE (Disease or injury that initiated events DUE TO (OR AS A CONSEQUENCE OF): reaulting in death) LAST d										
AL	PART II. Other significent conditions co	ontributing to death but no	ot resulting in the	underlying	ceuse given in		AN AUTOPSY		ERE AUTOPSY FINDINGS		
용							ORMED?	C	MILABLE PRIOR TO OMPLETION OF CAUSE		
Ę I							- CANIA	1	F DEATH?		
ÿ	DID TOBACCO USE CONTRIB	UTE TO CAUSE OF DE	EATH YES [NO 🗆	UNCERTAIN	VП					
₹	25. WAS CASE REFERRED TO MEDICAL	26. PL	LACE OF DEATH (Ch								
Sign	EXAMINER? 1 YES 2 MO HOSPITAL: 1 OTHER: 4 Nursing Home 5 Residence 6 Other (Specify)										
Y PHYSICIAN: MEDIC	27. MANNER OF DEATH 1 Maturel 5 Pending	28e. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJUF	Y AT	28d. DESCRIBE HOY	V INJURY OCC	CUREO			
red BY	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. PLACE OF INJURY — At building, etc. (Specify)	home, ferm, atreet,	me, ferm, atreet, factory, office 28f. LOCATION (Street and Numb. City or Town, State)					te Number,		
COMPLETED	29e. CERTIFFING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(e) and manner as stated. Check only one) 2 MEDICAL EXAMINER: On the best of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(e) and manner as stated.										
TO BE	30. NAME AND ADDRESS OF PERSON WHO CO	MARI ETED CAUSE OF DEATH (Trail on Care Ode	29d. DATE SIGNED (Month, Day, Visar) D 195/2 Decamber 14th 1995 The 206 Glen Burner, MJ 2106/							
	SANG () . H. M.). 31. DATE FILED (Month, Day, Year)	1600 CY	am Huy	J 5t.	206	Glin Bu	ma,	Mi	21061		
	DEC 1 8 1995	Jalia d'houlear Ro	whall						DMAIN 10 Page 1/00		



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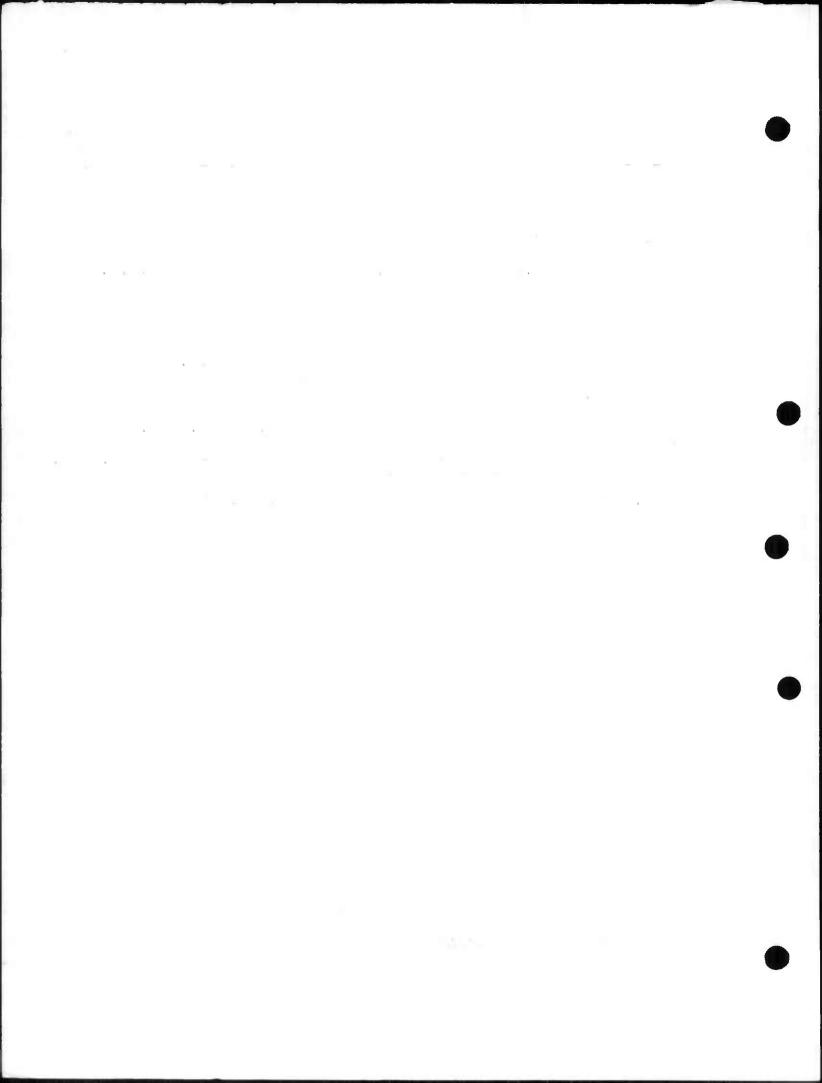
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTION: After this certificate has been signed by the attending physician and completely filled in by the funeral direction page 5 should be detached for use as the burial-transit permit. Pages 1. 2. 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: It item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF	MARYLAND /	DEPARTMENT	OF HEALTH	AND	MENTAL	HYGIENE	
	CI	ERTIFICATE	OF DEAT	TH		REG. NO.	

	FOR STATE REGISTRAR	STATE OF MARYLA		MENT OF H		MENTAL HYGIENI REG. NO.	E				
,	1. DECEDENT'S NAME (First, Middle, Last)	HENRY E.	RES	CH		2. DATE OF DEATH	Y 11995	3. TIME OF DEATH			
	218-42-6775	1 DM 2 DF 80		IF UNDER 1 YEAR KONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) 12-29-0	Countr	PLACE (State or Foreign y) Md.			
œ	9e. FACILITY NAME (If not institution, give stre				R LOCATION OF DE		9c. COUNTY OF D				
5	Northwest Hosp RESIDENCE OF DECEDENT	ıtaı			llstow	n	Baltim				
DIRECTO		Baltimore		TOWN OR LOCAT				10d. INSIDE CITY LIMITS? 1 YES 2 X NO			
	10e. STREET AND NUMBER										
FUNERAL	1003 Hartmont R	dBaltimo			2122		U.S.				
	1 Never Merried 2 Merried	FORCES? 1 YES	2 200	If yes, spe		IIC ORIOIN? (Specify Yee n, Puerlo Rican, etc.)	Braci Speci	E — Americen Indien, k, White, etc.			
D BY	3 X Widowed 4 Divorced 15. DECEDENT'S EDUCA	ATION	16a. DECEDENT'S U	SUAL OCCUPATIO	Au .	18b. KIND OF BUS	INECC/INDICTOV	White			
COMPLETED	(Specify only highest grade of Elementary/Secondary (0-12)	ompleted) College (1-4 or 5 +)	(Give kind of wo	rk done during mos	SINESS/INDUSTRY						
MPL	Grade 11		Mailm	an			U.S.Post Office				
	17, FATHER'S NAME (First, Middle, Last) George M. Res	oh			Sumeme)						
TO BE	19e. INFORMANT'S NAME (Type/Print)	CH	19b. MAILINO /	DDRESS (Street a		Oline Roll Poute Number, City or Town					
-	Lavern Furnes		544 W			-Balto	Md 2				
	t XBurlei 2 Cremation 3 Remov	rel from State ceme	tery, crematory or oth	er place)		12-15-95	West Edition				
	21. SIGNATURE OF FUNERAL SERVICE LICE		to heat	22. NAME AN	D ADDRESS OF FA						
	G. Truman S	chwah		Balt	imore.	Md. 2122	29	IRC			
	23. PART 1. Enter the diseases, or co ehock, or heert fellure. LI IMMEDIATE CAUSE (Final	let only one ceuee on ee	ch line.	_			ratory arrest,	Approximata Interval Between Onset and Death			
	IMMEDIATE CAUSE (Final disease or condition resulting in death) A SPIRATION POEUMONIA Due to (or as a consequence of):										
NO	Sequentially list conditions, Dije to (OR AS A CONSEQUENCE OF)										
CATI	if any, leading to immediate cause. Enter UNDERLYING										
CERTIFICATION	CAUSE (Disease or injury that initiated events DUE TO (OR AS A CONSEQUENCE OF):										
CER	d.										
CAL	PART II. Other algnificant conditions	contributing to death bu	it not reculting in	the underlying	cause given in	PERFOR	MED?	. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE			
PHYSICIAN: MEDIC						1 YES 2	No.	OF DEATH?			
AN:	DID TOBACCO USE CONTRI				UNCERTAI	N B					
SICI/		HOSPITAL:		OTHER:	e 8 Residence	8 Other (Specify)					
PHY	27. MANNER OF DEATH	28e. DATE OF INJURY (Month, Day, Year)	28b. T/ME INJU	OF 28c. INJ		28d. DESCRIBE HOW I	NJURY OCCURED				
BY	1 Nitural 5 Pending 2 Accident Investigation 3 Suicide & Could not be	28e. PLACE OF INJURY	M 1 TES 2 NO			281 LOCATION (Street a	and Number or Burni	South Mumber			
COMPLETED	3 Suicide 8 Could not be 4 Homicide determined	28e. PLACE OF INJURY — At home, ferm, street, fectory, office building, etc. (Specify) 281. LOCATION (Street and Number City or Town, Stete)						voite vurnoe,			
APLE	29e. CERTIFIER (Check only) Check only (Check only) (Check only)										
CO	one) 2 MEDICAL EXAM/NER: On the besis of examination end/or investigation, in my opinion, death occurred at the time, date end piece, end due to the ceuse(s) end menner ee stated.										
) BE	296. SIGNATURE AND TITLE OF CERTIFIER	rk_			D4-04	MBER [_9]	Dec.	(Month, Day, Year) : 12 - 199			
5	30. WAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF DEA	TH (ITEM 27) (Type, I	Print) Par	clal, 7	im na					
	DEC 1 8 1995	32. REGISTRAR'S SIGNA	TURE								
	DEC + 0 1333	- Annual Park									



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

	JMK.			State of Ma	arylanu / D	epartment of Certificate o	f Death		Reg. No.	38	165	
	Physici /Medi		Decedant's Name (First, Middla, Last Sharon Pa	atricia	Sambor	ski		2. Date of Dea Month Decembe	Day	Year	Tima ot Death	
<i>)</i>	Examii Funeral Director		4a. Facility Nama (If not institution, giv. 1602 Eastern Boule 5. Sociel Security Number 6. S 212 72 8174	evard	e (In yrs. last birth	Months Dev	Essex	6. Data of Birth	ath 4c. County of Death Baltimore		(State or Foreign	
	_		Usual Rasidance of Decedant 10a. Stata 10b. County		10c. City, Town	or Location		April	25, 1957		sida City Limits	
e Man	Affed at	Director	Maryland Baltimor	re e	Es	Essex					□Yas 2□No	
with th	3e or 2		10e. Straat and Number 1241 Damsel Road			10f. Zip Code 21 22			10g. Citizan of V			
urs after deet	2 should be filed within 72 hours after deeth with the Maryland and Mental Hygiene. Is marked other than "natural", or itema 23a or 28a-f show raumatic event, the Mayloral Examiner must be notified at	by Funeral	11. Marital Status 1 □ Navar Married 2 ☒ Marriad 3 □ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yas 2 ☐ N If Yas, Giva Yaar or Datas:		13. Was Decedant of It Yas, specify Co	of Hispanic Origin? (Suban, Mexican, Puer	Specify Yes or No- to Rican, atc.)		e - Amarican tne ck, White, atc.		
od within 72 hours af		Completed	15. Decedant's Ed (Specify only highast gra Elamentary/Secondery (0-12)	lucation da complated) Collaga (1-4or 5	+)	Pecedant's Usual Occ Give kind of work don ife. DO NOT use rat Nurse Aide		orking		usiness/Industry		
d 2 should be filed		Be	17. Fether's Neme (First, Middla, Last) Jack Connery,			naibe ma		ma (First, Middle,		ia)	:1	
d 2 shoul	d 00 =	To	19a. Intermant's Name/Ralationship (19a Bernard C. Sambors	Type, Print)		Mailing Addrass (Street 41 Damsel	eet and Numbar or R	ural Routa Numbe	r, City or Town,	Stata, Zip Code		
sermit. Pages 1 and	nt of Heelth Is if item 27 is r or other tra		20a. Mathod of Disposition 1 ↑ Burial 2 □ Cramation 3 □	Ramoval from Stata	20b. Place of C	Disposition (Name of cramatory or other p	plece)	Dete	20c. Location - City or		r Town, Stata	
permit. Pa	Department of Important: If it any Injury or o		4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Service Licen		Oak Law		y dress of Fecility Ski Funera cern Ave I		A.			
licete be executed	attending physician and addition use as the burlet transit	n/Medical Examiner	Immediata Causa (Final disease or condition rasulting in death) Sequentially list conditions, if any, leading to immediate cause. Entar Underlying Cause (Disease or injury that initiated evants rasulting in death) Lest	b	E INJURI Dua to (or as a co	nsequence of):					et end Death	
hat the deeth certif	ed by the atte	Physician/M	Part II. Other significant conditions or	ontributing to death bu	uting to death but not rasulting In tha undarlying cause given in Pert I.				obacco use col	ntributs to the	17	
law requires that	s been sign 2 should be	Completed by							/as an autopsy arlormed? 24b. Wara autops available pric completion of death?		prior to ion of cause	
an: The	Dag Dag	0	25. Was casa raferred to medical				26. Place of De	1 ☑ Y		1 🔀 Yes	2 No	
al or Attending Physician:	deeth. ctor: After this y the funeral di	Certification: To B	examinar? 1 Yes 2 No 27. Manner ot Death 1 Natural 5 Pending invastigation 2 Accidant invastigation 3 Suicida 6 Could not be datarmined		28d. Describe h Pedestr Struck b 28f. Location (S City or Tow	iance 6 10th low Injury occurre 1 an y motor Treet and Numb n, Stata)	vehicl	e ta Number,				
ospit	hour uners by filk	edical C		ystcian: To the best of iner: On the basis of and menner stell	t my knowledge, o				ausa(s) and ma	ınnar as stated.	ausa(s)	
To the	within 24 To the Fi	Me	29b. Signature end title of certifier Donald	. Wright	- MO	0.	C.M.E.		29d. Dete signed			
/	Sta Begistr		30. Nama and address of person who of DONALO G. WRIG, 31. Transfilled (Moeth, Day Seer)		111	ypa, Print) Penn Str	eet, Balt	imore, M	aryland	21201		

State Registrar DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Deeth **Physician** December 17, 1995 4:50 AM STITT Virginia /Medical 4b. City, Town, or Location of Death 4e. Fecility Neme (If not institution, give street end number) 4c. County of Deeth **Examiner** Franklin Square Hospital Center Rossville Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 12/15/1917 5. Sociel Security Number 9. Birthplece (Stete or Foreign Country)
Pennsylvania 7. Age (In yrs. lest birthday) **Funeral** 1 M XX 205-09-0678 Yrs. 78 Director Usuel Residence of Decedent the Meryland 10e. Stete 10b. County 10c. City. Town or Location 10d. inside City Limits 28a-f ahow the Medical Examiner must be notified at Maryland Baltimore 1 ☐ Yes 2√2 No Directo Essex 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 6 332 Homberg Avenue Items 23a 21221 U.S.A. filed within 72 hours efter death Hyglene. Ither than "natural", or Itema 23. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 전 No If Yes, Give Yeer or Detes: Wes Decedent of Hispenic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Bleck, White, etc. 11. Meritel Stetus 1 ☐ Never Merried 2 ☐ Married altimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: White þ 3 ☐ Widowed 4 ☑ Divorcad Completed 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grede completed) Elementery/Secondery (0-12) 1 2 Coilege (1-4or 5+) Book Keeper Utility Co. marked other 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) th and Mental F. 7 is marked out Pages 1 and 2 should be Eugene Robinson Agnes Mae Blystone 19e. Informant's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) : If Item 27 Stephen Marange 332 Homberg Avenue Balt., MD. 21221 20b. Pleca of Disposition (Name of cametery, crematory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete Department of H Important: If its any injury or of 1 XBuriei 2 ☐ Cremetion 3 ☐ Removel from Stete Presbyterian Cemetery 12/21/95 Mifflintown, Penna. 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Bruzdzinski Funeral Home P.A. 1407 Eastern Ave. Baltimore, Maryland 21221 23a. Part . Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, show or heart failure. List only one cause on each line. Approximete intervel Between Onset and Deeth **Physician** /Medical Immediete Cause (Final diseese or condition resulting in deeth) Examiner Due to (or es s consequence of). (QNO4 The lew requires that the death certificate be executed Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in deeth) Lest Due to (or es e consequence of): the buriel Division of Vital Records, P.O. Box 68760, physiclan Physician/Medical Due to (or es e consequence of) ettending p signed by the e Partil. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown Be Completed by ate hes been sig pege 2 should b 24b. Were autopsy findings available prior to 24e. Wes an sutopsy performed? completion of cause of death? 1 ☐ Yes 2 ☐ No certificate or Attending Physician: 25. Was case referred to medicel examiner? 28. Pleca of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 10 1 Yes 1 inpatient 2 ER/Outpetient 3 DOA this eral Director: After thi filled in by the funeral 28a. Dete of Injury (Month, Day Year) 27. Manner of Deeth Certification: 28b. Time of 28c. Injury st Work? 28d. Describe how injury occurred 1 Naturel 5 Pending investigation deeth. 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify) Pire 4 \ Homicide To the Hospital within 24 hours To the Funeral I Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, end due to the ceuse(s) and manner as stated.

2 Medical Examiner: On the basis of examineting end/or investigation, in my opinion, deeth occurred et the time, date end place, and due to the ceuse(s) end manner stated. 29e. Certifier Medical completely (Check only one) 29b. Signature and title of corp 29c. License number 29d. Dete signed (Month, Day, Year)

ath (Item 23e) (Type, Print)

1308

32. Registre's Signature

State Registrar 30_Name end eddress of person/wt

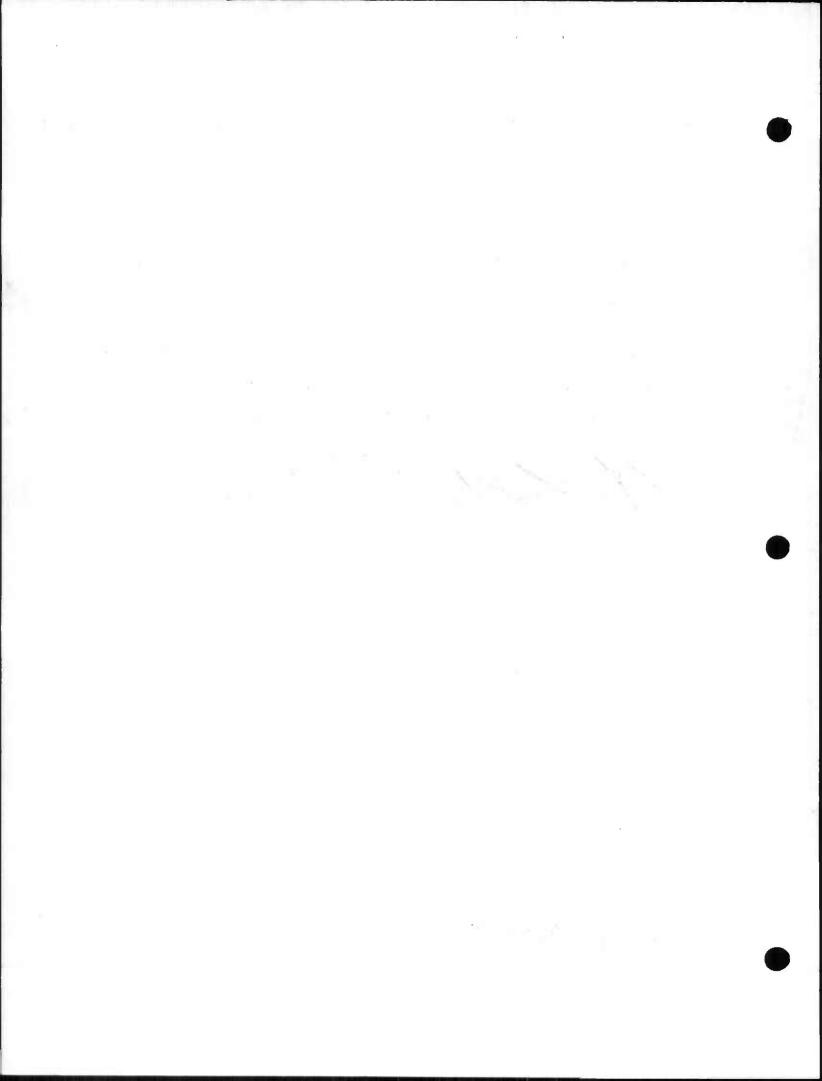
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	1 - STATE REGISTRAR	STATE OF N	MARYLAND C	/ DEPAR					ENTAL	REG. NO.			
	1. DECEDENT'S NAME (First, Middle, Last)	scone	- -						2. DATE O MONTH			YEAR	3. TIME OF DEATH 4:20 PM
1	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. Is	st birthday)	IF UNDER		IF UNDER		7. DATE O		7,7		PLACE (State or Foreign
	215-14-2269	1 M 2 □ F	72	YRS.	MONTHS	DAYS	HOURS	MIN.		4,192	23		ŔYLAND
~	90. FACILITY NAME (If not institution, give ST. AGNES HOSPIT							ON OF DEA	TN			NTY OF DE	
5	RESIDENCE OF DECEDENT				BALT	IOMI	RE		BALTIMORE CI			RE CITY	
DIRECTOR	10a. STATE 10b. COUNT	гү		10c. CI1	Y, TOWN	OR LOCAT	ION						10d. INSIDE CITY LIMITS?
		HOWARD]	ELKR]	DGE							1 TYES TO NO
FUNERAL	10e. STREET AND NUMBER			101.	ZIP CODI				10g. CIT		HAT COUNTRY?		
NE I	7248 MONTGOMERY	ARMED	- 10			2122	·			U.S			
BY FU	1 Never Married 2 Married 3 Widowed 4 Divorced	NO	- 1 - 4	If yes, spe	cify Cuba	n, Maxican, Specify:	, Puerto Ri	(Specify Year	or No —	14. RACE Black Specif	— American Indian, , Whits, etc.		
ED	15. DECEDENT'S EDI (Specify only highest grad		16a. C	ECEDENT'S	USUAL O	CCUPATIO	N et of workin	v.	16b.	KIND OF BUS	INESS/INC	DUSTRY	
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COMPLETED	7THGRADE 17. FATHER'S NAME (First, Middle, Lest)			IECHANIC 18. MOTNER'S NAM								OBIL	ES
E CC	UNKNOWN SLO	NE.						A WO	_ ,	iddle, Maiden S	Surnama)		
00	19a. INFORMANT'S NAME (Type/Print)		-	19b. MAILIN	G ADDRES	S (Street a				er, City or Town	, State, Zij	Code)	
2	EMMETT SLONE, JR	. •	7	810 (CLARK	ROA	AD -	JESS	UP,	MARY	LAND	2	0794
	20a. METHOD OF DISPOSITION 14 Buriel 2 Cremation 3 Res	movel from State		E AND DATE					DATE		CATION -	City or To	wn, Stata
- 8	4 Donation 5 Other (Specify)		CRES	TLAW					12/	19 MA	RRIC	TTSV	ILLE
	22. NAME AND ADDRESS OF FACILITY HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVENUE—BALTIMORE, MD 21229 23. PART L Enter the diseases, or complications that caused the Geeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate												
	23. PART I. Enter the diseases, or	complications the	at caused the	Seeth. Do									Approximata Interval Between
												Onset and Death	
8	DUE TO (OR AS A CONSEQUENCE OF):												
CERTIFICATION	Sequentially list conditions, if any, leading to immediate Due TO (OR AS A CONSCOUENCE OF):												
CAT	ri any, teading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury												
H	that initiated events resulting in death) LAST												
H	resulting in death) LAST												
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MEDI									<u> </u>	/	X		1 TYES 2 NO
ä	DID TOBACCO USE CON	TRIBUTE TO CA					UNC	CERTAIN	12				
ICIA	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:		ACE OF DE	OTHE	R:							
PHYSICIAN:	1 YES 2 NO	1 2 Inpetient 2	ER/Outpatient	3 🗆 DOA		28c, INJ		esidence ((Specify) CRIBE NOW II	UURY OC	CURED	
	1 Natural 5 Pending		Day, Year)		IJURY M	WO	RK7 YES 2	NO		(
D BY	3 Suicide 8 Could not be	home, farm,	farm, street, factory, office 28t. LOCATION (Street and Number or Rural Route Number, City or Town, State)					Route Number,					
TED	4 Nomicide determined		, etc. (Specify)						Ony c	in lown. Grazey			
COMPLET	29a. CERTIFIER (Check only 1 CERTIFYING PNY	SICIAN: To the best of	t my knowledge,	death occur	red at the	time, data	and place	, and due t	to the cau	se(a) and men	ner aa ati	rted.	
OM	one) 2 MEDICAL EXAMINER: On the beals of examination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(a) and menner as stated.												
ш	296. SIGNATURE AND TITLE OF CENTRE	2	_				29c. LIC	ENSE NUM	BER		29d. DA	TE SIGNED	(Month, Day, Year)
TO B										6/55			
	FIED CRUK	COMPLETED CAL	JSE OF DEATH (IT	3 4	e, Print) 49	110	110	ns 1	400	B	Ita	10/0	MO ZIZZ9
	31. DATE FILED (Month, Day, Year)	A2 REGISTR	AR SIGNATURE		· /	001	. 100	,	, 00	100	cille	WIE	, ,,,,,,,,
	1 0 400F 3	The Hiller Wall	- NAMOURAL !										



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	28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notifile	
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DECEMBER SHAME AND ASSOCIATED STATE OF DEATH AND ASSOCIATED SHAME AND AS		1 - FOR STATE REGISTRAR	STATE OF MARYLAND / DEPARTM CERTIFICA	ENT OF HEALTH AND MATE OF DEATH	ENTAL HYGIENE REG. NO.						
SOCIAL SECURITY NUMBER 1 S. SEX F 9 yrs, but brindow F 40000 1 Sex Sex		1. DECEDENT'S NAME (First, Middle, Last) ISHAM	Smith		2. DATE OF DEATH MONTH DAY	VEAR 1					
BODY TABLE (THE ADMINISTRATE OF ADMINISTRATE O		337-46-11	CIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. lest birthdey) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year) (Month, Day, Year) Country (Month, Day, Year)								
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PART II. Other significant conditions contributing to death but pot resulting in the Theoretising cause given in Part I. CARCINOMA 6	E										
Chronic organic brain Synarome Chronic organic brain Synarome 25. Was case referred to Medical Examiner? 1 yes 2 no 26. Place of Oeath (Check only one) Examiner? 1 fres 2 no 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Injury (Month, Day, Year) 28b. Time of Injury (Month, Day, Year) 28c. Injury at Work? M 1 yes 2 no COMPLETION OF CAUSE OF DEATH? 1 yes 2 no COMPLETION OF CAUSE OF DEATH? 1 yes 2 no COMPLETION OF CAUSE OF DEATH? 1 yes 2 no COMPLETION OF CAUSE OF DEATH? 1 yes 2 no				Underlying cause given in Pa	art I. 24a. WAS AN AUTOPSY						
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1.	EDIC	Chrony	a of the	TOSTATE	1	COMPLETION OF CAUSE					
2 Accident Investigation M 1 YES 2 NO	. M	gotten a L	Hit Ha	r) synaro,	me	1 TES 2 NO					
2 Accident Investigation M 1 YES 2 NO	CIA	EVAMINEDO	OCCUPAL.		only one)						
2 Accident Investigation M 1 YES 2 NO	IXSI	1 YES 2 NO	☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐	Nursing Nome 5 Residence 6							
		Natural 5 Pending	(Month, Day, Year) INJURY	8d. DESCRIBE HOW INJURY OC	CURED						
29a. CERTIFIER (Check only Ch		3 Suicide 6 Could not be	Suicide 6 Could not be 28s. PLACE OF INJURY — At home, ferm, streat, factory, office building, stc. (Specify)								
(Check only one) (Check one) (Check only one) (Check only one) (Check only one) (Check only	LET	4 Homicide determined City or Yown, State)									
O MEDICAL EXAMPLES: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and placs, and due to the cause(s) and manner as stated.	OMP	(Check only one) # MEDICAL EXAMINER: C	Y: To the best of my knowledge, death occurred at the control of the basis of examination and/or investigation, in r	he time, dats and place, and due to my opinion, death occured at the time	the cause(s) and manner as staten, data and place, and due to the	e CSuse(s) and manner as stated					
29b. MACHATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Digy, Year)			1.00								
0 12/14/95		an MAME AND RODER OF THE SECOND	reng	D18327 12/14/95							
moges Gebrenamam. 4660 Wilkers Ave Ralto 21279		man and the		1.1hours Mars	Rad L -	2/279					
31. DATE FILED (Month, Day, Year) DEC 1 8 1995 JAP, REGISTRAFT SIGNATURE	1		/ ME E LIGHT TOTAL TOTAL		45 / F W W W W W W W W W W W W W W W W W W						

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-train be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumattic event, the medical examiner must be notified at once.
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DIVISION OF VITAL RECORDS, P.O. BOX 68760

BALTIMORE, MARYLAND 21215-0020

FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAR		CE	ERTIFI	CATE C	F DEATH		REG. NO.				
i	1. DECEDENT'S NAME (First, Middle, Last)						2. DATE OF	DEATH			3. TIME OF DEAT	ТН
,	CHARLES ELBER	RT SHIF	FLETT				Dec	15	199	YEAR	9:50	ДМ
1	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs les	t birthday)	IF UNDER 1 YE	AR IF UNDER 24 HRS.	7. DATE OF	BIRTH		a. BIRTHE	PLACE (State or Fo	
	223-38-2957	1 🔀 M 2 🗆 F	63	YRS.	MONTHS DA	YS HOURS MIN.	(Month, D	26,1	932	Vir	ginia	
1	9a. FACILITY NAME (If not institution, give s	treet and number)			9b. CITY, TO	WN OR LOCATION OF D			9c. COUN		_	
DIRECTOR	Johns Hopkins	Bayview	M.C.		Balt	imore			N/A			
3	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY	Υ		10c. CITY	0c. CITY, TOWN OR LOCATION 10d, INSIDE CITY							
5	Maryland N/A			B:	altim	ore				- 1	LIMITS?	
- 11	10e. STREET AND NUMBER			1 100	AT CIM	10f. ZIP CODE		10g. CITIZEN OF W				
UNERAL	5015 E. Oliver	Street		21205					US	SA		
5	11. MARITAL STATUS	12. WAS DECEDENT FORCES? 1.	EVER IN U.S. AR	MED		DECENDENT OF HISPA			or No-	14. RACE	- American India White, etc.	en,
10	1 Never Married 2 Married 3 Widowed 4 Divorced	IF YES, GIVE W	R OR DATES		1 VEC 2 X NO Specific							
20			ean Wa		EDENT'S USUAL OCCUPATION 166. KIND OF BUSINESS/INDUSTRY							
	(Specify only highest grade completed) (G				ork done durin e retired.)	g most of working	16b. KI	ND OF BUS	INESS/INDU	JSTRY		
	Elementary/Secondary (0-12)	College (1-4 or 5 +		1esm	,		M.	attr	055	Com	nanzı	75.77
OMPLE	17. FATHER'S NAME (First, Middle, Last)		100	TCOR	id II	18. MOTHER'S N.				COM	parry	
ן כ	Charles Shiff	1ett				Nora	Roach					
DE	19s. INFORMANT'S NAME (Type/Print)		19	b. MAILING	ADDRESS (Str	eet and Number or Rural	Route Number,	City or Town	, State, Zip	Code)		
-	Helen Shiffle	tt		5015	E. (liver St	t. Ba	alti	more	, M	d 2120	5
	20s. METHOD OF DISPOSITION 1X Burlet 2 Cremetion 3 Rem	oval from State	20b. PLACE		F DISPOSITIO	N (Neme of	DATE	20c. LOC	CATION — C	Ity or Tov	vn, Stela	
	4 Donation 5 Other (Specify)				Ceme	etery	12-19	Ba	ltim	ore	, Md	
1	21. SIGNATURE OF FUNERAL SERVICE LIC	CENSEE	0	11		onnelly		31 U	0.000	Of .	Dunda 1	le.
	Unthony	Colt (one	Uly		.10 Solle						1/2
TITICALION	ahock, or heart fellure. List only one cause on each line. Interval Between Oneat and Daath CLUTE M 7 Due TO (OR AS A CONSEQUENCE OF): Due TO (OR AS A CONSEQUENCE OF): Due TO (OR AS A CONSEQUENCE OF): Due TO (OR AS A CONSEQUENCE OF): Due TO (OR AS A CONSEQUENCE OF): Due TO (OR AS A CONSEQUENCE OF): Due TO (OR AS A CONSEQUENCE OF):											
3												
MEDICAL	PERFORMED? AMAIL 1 VES 2 NO OF DI									WERE AUTOPSY FI AVAILABLE PRIOR COMPLETION DF 0 OF DEATH? 1 YES 2	CAUSE	
PH TOICIAN:	DID TOBACCO USE CONT	RIBUTE TO CA			S L NC		N L				<u> </u>	
	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:			OTHER:			- 1 7				
2	1 YES 2 NO	1 Inpetient 2		28b. TIM		Home 5 Rasidenca	· ·	Specify)	LINBA UCC	HIBED		_
	1 Netural 5 Pending	(Month, De	y, Year)	iNJ	URY	WORK?	200.0200	not non n		OHLD		
	Accident investigation 3 Suicide 6 Could not be	26s. PLACE OF	INJURY — At he	ome, ferm, s	treet, factory,	offica			nd Number	or Rural A	oute Number,	
4	4 Homicide datarmined	building,	City or Town, St				Town, State)					
OMPLE	cond only					data and place, and du					and menner as s	stated.
בי בי	29b. SIGNATURE AND TITLE OF CERTIFIE	R . D	0.0	/	0	29c. LICENSE NU					(Month, Day, Year)	
2			Sayar			D18°	15/ 12-			2-	18-55	
	30. NAME AND ADDRESS OF PERSON WH Reza Sajadi M	.D. 10) N. B			Baltimo	ce, Mo	d 212	231			
	DFC 1 8 1995	32. PEGISTRA	AL ANATHRA									
N												

DHMH-16 Ray 1/89

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t			

		- STATE REGISTRAR CERTIFICATE OF DEATH	REG. NO.		
		1. DECEDENT'S NAME (First, Middle, Lest) ANNA MARY SHECKELLS	2. DATE OF DEATH	YEAR	. TIME OF DEATN
		4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS.	December 1 7. DATE OF BIRTH	a BIRTNE	ACE (State or Foreign
9.		215-07-4344 1 - M 2 DF 86 YRS. MONTHS DAYS HOURS MIN.	JAN. 11,18	Country)	yland
2, 3 970	E E	9a. FACILITY NAME (If not institution, give street and number) Harbor Hospital Center Baltimore City		C. COUNTY OF DEA	TN
2.7	DIRECTOR	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION		N/A	
8	DIRE	TOUR OF LOCATION	re Highland	~ \	Od. INSIDE CITY LIMITS? YES 2 X NO
E S	RAL	10e. STREET AND NUMBER 10f. ZIP CODE		0g. CITIZEN OF WH	
Durial-Dansit permit.	FUNERAL	11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECEMBENT OF HISPAN	IIC ORIGIN? (Specify Yes or I	USA No 14. RACE -	- American Indian,
	BY F	1 Never Married 2 Married FORCES? 1 YES 2 X NO If yes, specify Cuban, Markea 1 YES 2 X NO Specify Cuban, Markea 1 YES 2 X		Black, \ Specify:	WHITE
use as are	品	15. DECEDENT'S EDUCATION (Specify only highest grade completed) [Give kind of work done during most of working life. Do NOT use retired.]	16b. KIND OF BUSINE		MILLIE
in the second	COMPLETED	Elementary/Secondary (0-12) UNKNOWN College (1-4 or 5+) Toy Watch Maker		er Woods Ity Co.	
at once.	CON	17. FATNER'S NAME (First, Middle, Last) 18. MOTHER'S NAME T	ME (First, Middle, Malden Surn	name)	
notified a	BE	19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural F		ans	
	5	Mr. George W. Beck 21 Arkla Court, Balt	imore, Md. 2	21228	
wai.		20e. METNOD OF DISPOSITION 1 X Burlai 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Parkwood Cemetery Dec. 1	DATE 20c. LOCATI	ima ya M	, State
examiner		21. SIGNATURE OF FUNERAL SERVICE LICENSEE KOVIN L LOVOK 122. NAME AND ADDRESS OF FAC	CHITY		
oval.		McCully Fune 237 E. Patap	sco Ave., Ba	alto., M	d. 21225
on, or removal		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such shock, or heart fallure. List only one cause on each line. IMMEDIATE CAUSE (Final	n aa cardiec or reapirato	ory arrest,	Approximata Interval Between Onset and Death
, e = 1		disease or condition resulting in death) Disseminated Julia vascula Due to (or as a consequence of):	1 Coagu	lation	6 dan
urial, cremati ic event, t	z	Re nel Lajure			(days
rior to burial, crema traumatic event,	ATIO	Sequentially list conditions, If any, leading to immediate cause. Enter UNDERLYING			1
ntal Hygiene prior to	IFIC	CAUSE (Disease or Injury that initieted events Due TO (or as a Conscouence of):			6 days
y, or o	CERTIFICATION	resulting in death) LAST (Ingewia			<u> </u>
B =	DICAL	PART II. Other significant conditions contributing to death but not resulting in the undarlying causa given in	Part I. 24a. WAS AN AUTO PERFORMED		ERE AUTOPSY FINDINGS MILABLE PRIOR TO
N Sea	MEDI		1 TES 2	NO O	OMPLETION OF CAUSE F DEATH?
\$ P	N.	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN	10		TES 2 NO
State	PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 VES 2 NO 1 Mospital: 1 Mospita			
with the	PHY	27. MANNER OF DEATN 28a. DATE OF INJURY (Month. Day. Year) 28b. TIME OF INJURY AT INJURY MORKS MORKS	28d. DESCRIBE NOW INJUR	RY OCCURED	
s marked	B	1 Matural 5 Pending M t YES 2 NO 3 Suicide 6 Could not be 28a. PLACE OF INJURY — At home, tarm, street, factory, office	281. LOCATION (Street and A	Market 19 19 19 19 19 19 19 19 19 19 19 19 19	- 11 1
ate 28	ETED	4 Homicide determined building, etc. (Specify)	City or Town, State)	vumber or Hural Hou	e Number,
N -	COMPLI	29a. CERTIFIER (Check only one) The provided state and place and due to the state and due to the state and due to th			
Within 72 STANT: If		2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the second structure. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUM			
be filed within ?	O BE	APC. LICENSE NOW		December	1 13 th (99)
	-	P. Shamp House STAFF. AS-24 30. HAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Typo, Print) PRATIBHA SHARMA - HARBOR HOSPITAL	(FASEA	- HANC	VER ST
		31. DATE FILED (MORTH DOW MAY) 8 1995 32. REGISTRARY SIGNATURE RANGE	Cirion	7	
	10	DEU - U 1000 /7" TT			

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

DNMN-16 Rev 1/89

1995 9:43

n/a

10g, CITIZEN OF WHAT COUNTRY?

USA

Specify:

9c. COUNTY OF DEATH

3. TIME OF DEATH

1 X YES 2 NO

a. BHRTHPLACE (State or Foreign Country/West Africa Sierra Leone

14. RACE — American Indian, Black, White, etc.

Black

Approximate

Interval Between

Onast and Death

Freyers

245 WERE AUTOPSY FINDINGS

AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?

1 YES 2 TONO

29d. DATE SIGNED (Month Day Year)

L9700

Junas Hopkins

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FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

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2. DATE OF DEATH TIMITY THEODORA DECEMBER 13, 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year) MONTHS DAYS 1 M 2 X F 32 YRS. HOURS 577-96-3029 July 8, 1963 permit. Pages 1, 2, 3 should Ba. FACILITY NAME (If not institution, give street and number, 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY DIRECTOR THE JOHNS HOPKINS HOSPITAL RESIDENCE OF DECEDENT 10a. STATE 10h COUNTY 10c. CITY, TOWN OR LOCATION Maryland Anne Arundel Crofton FUNERAL 10e STREET AND NUMBER 101 ZIP CODE use as the burial-transit 2110 Lang Drive 21114 24 hours after death. Page 6 may be retained by the hospital or attending physician. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR OATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-1 Never Married 2 Married Il ves, specify Cuban, Maxican, Puerto Rican, etc.) 1 YES 2 X NO Specify: ΒY 3 Widowed 4 Divorced 15. DECEDENT'S EDUCATION COMPLETED 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY ĮQ. Elementary/Secondary (0-12) College (1-4 pr 5 +) College Administrative Assist. Dept of Justice US Govt. once. 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Surname) 9 76 Roland J. R. Timity Helen M.O. Johnson BE notified page 5 should 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Roland J. R. Timity 1904 Sheffield Court Severn, Maryland 21144 pe 20e_METHOD OF DISPOSITION
1 (ABuriel 2 | Cremation 3 | Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of Decate 20c. LOCATION - City or Town, Stata must funeral director, Meadow Ridge Cemetery Howard County, Maryland 23 4 Donation 6 Other (Specify) examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Nutter Funeral Homes, Inc. 2501 Gwynns Falls Parkway 4 erbe nutter Baltimore, Maryland 21216 filled in by the fi medical 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert failure. List only one cause on each line. IMMEDIATE CAUSE (Finel the cremation, disease or condition resulting in death) Pulmonary Hypertonsion event, in and com to burial, (traumatic CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediata 90 attending physician the attending physician Mental Hygiene prior cause. Enter UNDERLYING certificate CAUSE (Disease or Injury other OUE TO (OR AS A CONSEQUENCE OF): thet initiated eventa resulting in death) LAST 6 Injury. PART II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a WAS AN AUTOPSY MEDICAL Health and any ummon variable IMMUNE 1 IDAES 2 TI NO shows a certificate has been in the State Dept. of I DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) Item EXAMINER? HOSPITAL:
1 Unipetient 2 ER/Outpetient 3 DOA OTHER: 4 ☐ Nursing Home 6 ☐ Residence 6 ☐ Other (Specify) the 6 27. MANNER OF DEATH 26a. DATE OF INJURY (Month, Day, Year) 26b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED with t marked, 1 Netural 5 Pending Investigation 1 YES 2 NO DIRECTOR: After the hours after death v BY 2 Accident 28e. PLACE OF INJURY — At home, larm, street, factory, office building, etc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 50 COMPLETED 6 Could not be 28 4 Homicide Item 29e. CERTIFIER
(Check only one)

A MEDICAL SYMMER: On the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. FUNERAL I -2 MEDICAL EXAMINER: On the basis of exemination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(e) and menner as stated. IMPORTANT: 29b. SIGNATURE AND 29c. LICENSE NUMBER

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH



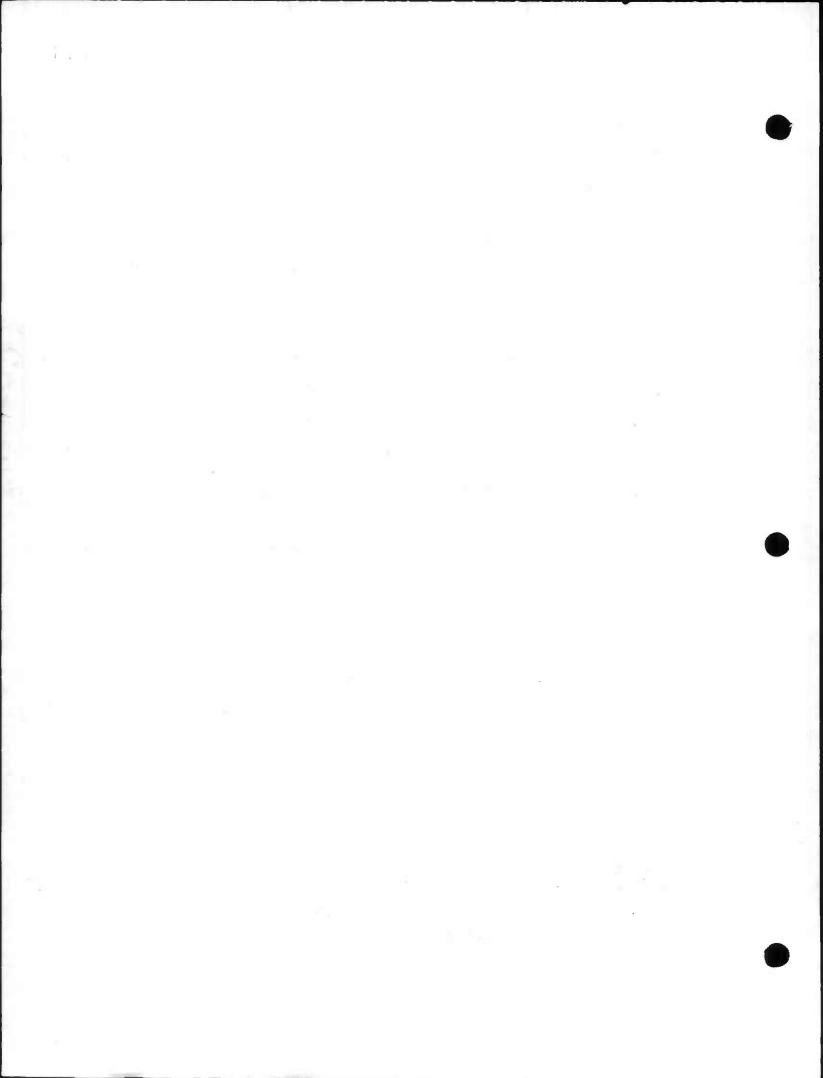
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31. DATE FILED (Mornin, Dal. Year) 1 8 1995

1906

32 REGISTRAR'S GIGNATURE



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 95 38 | 7

					C	ertificate d	of Death		Re	eg. No.	0	017	Same .
	Charain.		1. Decedent's Name (First, Middle, Last)						ata of Deat	-	Year	3. Time of De	eath
J	Physici /Medio Examir	al	Charles William 4a. Facility Nama (If not institution, give s	m Vaughan,	Jr.		4b. City, To		ec.	8 1	995	1:00	_am
0 10 10 10 10 10 10 10 10 10 10 10 10 10	Funeral Director	ler	3648 Forest Ga 5. Social Security Number 6. Sex 578-52-9340	arden Avenu		Months Da		more, 24 Hrs. 8. D. Min.	MD ate of Birth fonth, Day,	Balti	MOTE 9. Birthplac	ce (Stata or F	
	anyland ahow	1	Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or	Location						I. Inside City L	Limita
	or 28a-f	Director	MD Baltimon 10e. Street and Number	re Ba	ltim	10f. Zip Coc	le .		10	Og. Citizen of V	What Country		
0	n 72 hours after death with the Maryland "natural", or items 23s or 28s-f show splice Examiner man be notified at	Funeral	3648 Forest Gall 11. Marital Status 1 Never Married 2 Married	12. Was Decedant Evar in U, Armed Forces? 1 ☐ Yes 2 ☐ No	,S. 1	212(3. Was Decedent If Yes, specify (1 ☐ Yes 2 🕅	of Hispanic Orl Cuban, Mexical		as or No-	Blac	e - Amarican ck, White, etc		
5-002	2 hours	ted by	3℃ Widowed 4 Divorced 15. Decedent's Educ	If Yes, Give Year or Dates:	16a. De	cedent's Usuai Oc	cupation			Specify 16b. Kind of Bu	BTac		
21215-0020	d within jiena. r than	Completed	(Specify only highest grade	Coilege (1-4or 5+)		ive kind of work do a. DO NOT use re ancial			(Greater Busi		ington Bureau	
pu	be filed tel Hygi d other event, to	Bec	17. Father's Name (First, Middle, Last)					er'a Name (Firs	t, Middle, M	faiden Sumam	10)		
Maryland	d 2 should be filed the and Mentel Hyg. 7 is marked othe traumatic event.	To	Charles Willian 19a. Informant's Name/Relationship (Typ.		19b. Ma	alling Address (Sti	reet and Number		te Number,	City or Town,	State, Zip C	ode)	
e, N	1 and 2 Health em 27 i		Vivian Braxton-S 20a. Method of Disposition	20b. P	dace of Dis	48 Fore	F	2120	venu	20c. Location -	City or Town	State	
Baltimore,	permit. Pages 1 and Department of Healt Important: If item 27 any Injury or other I	0	1X Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	emoval/from State Ft	emetery, c	oln Ceme	etery	Dec	3.4	Brentwo			.d
Bal	Depar Impor any Ir		21. Signature of Funeral Service Library	1		Nutter 2501	Funo	× 1 II	ome Pkwy	r. Bal	to	MD 2	1216
	Physician		23a. Part1. Enter the disease, or complic ahock, or heart failure. List only on	cations that can be the death e ceusa on each line.	h. Do not	enter the mode of	dying, such as	cardiac or reas	piratory arre	est,	In	pproximate nterval Betwee Inset and Dea	en ath
	/Medical Examiner		Immediate Cause (Final disease or condition rasulting in death) a.	End Stuge Due to (o	er as a cons	Renul d	secuse						
	outed nd nansit	Examiner	Sequentially liet conditions	Due to (o	A. D.G	Spyr d	ylihis						
68760,	certificate be executed uding physician end use es the burial-transit	edicai Ex	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disaase or Injury that initiated events	Chions	dise	•							
Box 68		2	resulting In death) Last										
O. B	the death ce y the ettendi ached for use	Physician/	Part II. Other eignificant conditions cont	tributing to death but not rea	ulting In the	a underlying cause	given in Part I	. :	23b. Did to	bacco use co	ntribute to th	he cause of d	death?
s, P.O.	v requires thet the death or been signed by the ettend should be detached for us	by Phy	Recurrent	Septic hips	B	latinal	4.		1 🗆 Ye	2 × No	3 Probat	bly 4 □ Uni	known
Division of Vital Records,	8 8 8	Completed						2	4a. Wes ar perform		availe	autopsy find able prior to oletion of caus ath?	
al R	The ate h	Con							1□ Ye	s 251No	101	Yes 20 No	>
Z.	Physician: The this certificate ral director, pag	To Be	25. Waa case referred to medical examiner? 1 Yes 2 No	ospitai:	ER/Outpat	tient 35 DOA	Other	of Death (Che			or (Consilu)		
on of	ding Physith. After this funeral di		27. Manner of Death Natural Death Solution Natural Solution Investigation	28a. Date of Injury (Month, Day Year)	28b. Time injur	e of 28c. I	njury at Work? 1 □ Yes 2 □	28d. [w Injury occur			
Divis	To the Hospital or Attending Phwithin 24 hours efter death. To the Funeral Director: After thi completely filled in by the funeral	Certification:	3 Sulcida 6 Could not be detarmined	28e. Placa of Injury - At he building, atc. (Specify		atreet, factory, off	ica	28f. L	ocation (Sti lity or Town	reet and Numb , State)	er or Rural R	Route Number	r,
	To the Hospital of within 24 hours early to the Funeral Completely filled	edical	29a. Certifier (Check only one) 1 Certifying Physical Cambridge (Check only one) 2 Medical Examination	Ician: To the best of my knower: On the basis of examinat and manner stated.	wledge, de tion and/or	ath occurred at the Investigation, in n	e time, date an ny opinion, dea	d place, and di th occurred at	ue to the ca the time, da	use(s) and ma ate and place,	inner as atate and due to th	ed. na cause(s)	
	To the Com	Σ	29b. Signatura and title of certifier **Aum Mail **Tarm	2			ansa number			9d. Data signe			
	10		X arm mt. 30. Name and address of person who con Kaush Permanente,	mpleted cause of death (Item	23a) (Typ	pe, Print)	0412	2 3		12/11/9	15 -		
	1		Kaun Permanente.	Karein M.	Piper	, mo 7	141 Sec	wing B	rd	Butima	ire mo	2124	14.
	Sta	te	31. Data filed (Month, Day, Year)	32. Registrar's Signa	ture L								

TO THE HOSPITAL, OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burlat-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burlat, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

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1 - STATE REGISTRAR	STATE OF MAI			T OF HEALTH AND E OF DEATH	MENTAL HYGIEN	Ε		
1. DECEDENT'S NAME (First, Middle, Las	it)				2. DATE OF DEATH	-	3.	TIME OF OEATH
Norman	W	EISGARBE	ER		December		95 6	:20 P
4. SOCIAL SECURITY NUMBER		AGE (In yrs. last birt		R 1 YEAR IF UNDER 24 HRS.				ACE (State or Foreign
149-10-9171	1 😡 M 2 🗆 F		PS. MONTHS	DAYS HOURS MIN.	(Month, Day, Year)		Country)	
9a. FACILITY NAME (If not institution, give		89`		Y, TOWN OR LOCATION OF	11/11/19			sylvania
Franklin Squa	re Hospita	al Cent		Rossville	DEATH		y of oeat	
RESIDENCE OF DECEDENT 10a, STATE 10b, COUNTY			c. CITY, TOWN				Ι.,	
10		10						d. INSIDE CITY LIMITS?
-	ltimore		Mid	dle River				AES 5X 740
10e. STREET AND NUMBER				101. ZIP COOE		10g. CITIZI	EN OF WHA	T COUNTRY?
220 Stevens Re	oad			21220		U.S	A.	
11. MARITAL STATUS	12. WAS DECEDENT FORCES? 1	YER IN U.S. ARMED	13.	WAS DECENDENT OF HISP				American Indian, hita, atc.
1 Never Married 2 🔀 Married 3 Nidowed 4 Divorced	FORCES? 1 A	OR DATES		If yes, specify Cuben, Max 1 YES 2 NO Spe				White
15. DECEDENT'S E	DUCATION	16a. DECED	ENT'S USUAL C	OCCUPATION	16b, KIND OF BU	SINESS/INDU	STRY	
(Specify only highest gra	ade completed)	(Give k	ind of work done NOT use retired.)	during most of working			_,	
Elementary/Secondary (0-12)	College (1-4 or 5+)		inist		U.S.	Corre	*****	nt
17. FATHER'S NAME (First, Middle, Last)		Placif	THIDL				T IIME	:116
John A. Weisga	arbor				NAME (First, Middle, Malden			
	arner				h E. Dilk			
19a, INFORMANT'S NAME (Type/Print)	b			SS (Street and Number or Rur				
Margaret Weis	garber	22	U Ste	vens Rd.	Baltimore	, MD.	212	20
20s. METNOD OF DISPOSITION 1 Burlal 2X Cremation 3 Re	amount from State	20b. PLACE AND	DATE OF DISPO	SITION (Name of	DATE 20c. LO	CATION - C	ity or Town,	Stata
4 Donation 5 Other (Specify)	amovai trom sum	Greenmo	ory or other place ount C	emetery 12	/15/1995	Balt	imor	e. MD.
21. SIGNATURE OF FUNERAL SERVICE		100	22.	. NAME AND ADDRESS OF	FACILITY			
6 10 7	Saude	earth	B:	ruzdzinsk	i Funeral	Home	P.A	١.
June 1	July O		1.	407 Old Ea	stern Ave.	Balt	M	ID. 21221
23. PART I. Enter the diseases, o	or complications that c	aused the death						Approximata
	re. Liet only one ceuse	on each line.						Onset and Dasi
iMMEDIATE CAUSE (Final disease or condition	0 -	C .1	*					Oliset and Daa
resulting in death)	. Cancer o							
	DUE TO (OF	R AS A CONSEQUE	NCE OF):					4months
				1				4months
	D.			,				4months
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if any, leading to immediate cause. Enter UNDERLYING	DUE TO (OF	R AS A CONSEQUE	NCE OF):					4months
if any, leading to immediate	c	R AS A CONSEQUE						4months
if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury	c			,				4months
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If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significent condit DID TOBACCO USE CON 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATN 1 Natural 5 Pending Investigation 2 Accident 3 Suicide 6 Could not detarmined 29s. CERTIFIER (Check only) CERTIFYING PN	DUE TO (OF d. DUE TO (OF d. DUE TO (OF d. DUE TO (OF d. DUE TO (OF d. DUE TO (OF DUE TO (OF d. DUE TO (OF	SE OF DEATH 26. PLACE O R/Outpatient 3 JURY Year) NJURY — At home, c. (Specify)	YES THE OF DEATH (Check DOA 4 Nu St. TIME OF INJURY M farm, streat, led	NO UNCERTA k only one) ER: raing Home 5 G Rasident 2ec. INJURY AT WORK? 1 YES 2 NO ctory, offica	PERFOI 1 YES 2 AIN 286. Describe How 286. Location (Street City or Town, State) due to the cause(a) and mathe time, data and place, and NUMBER	INJURY OCCI	JRED JRED d. cause(s) as	ERE AUTOPSY FINDING. ARLABLE PRIOR TO DIMPLETION OF CAUSE DEATH? YES 2 NO NO NO Number, and manner as stated. Onth, Day, Year)
if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significent conditions of the condition of the condi	DUE TO (OF d. DUE TO (OF d. DUE TO (OF d. DUE TO (OF d. DUE TO (OF d. DUE TO (OF DUE TO (OF d. DUE TO (OF	SE OF DEATH 26. PLACE O R/Outpatient 3 JURY Year) NJURY — At home, c. (Specify)	YES THE OF DEATH (Check DOA 4 Nu St. TIME OF INJURY M farm, streat, led	NO UNCERTA k only one) ER: ursing Home 5 Raeidene 2ec. INJURY AT WORK? 1 YES 2 NO ctory, offica	PERFOI 1 YES 2 AIN 286. Describe How 286. Location (Street City or Town, State) due to the cause(a) and mathe time, data and place, and NUMBER	INJURY OCCI	JRED JRED d. cause(s) as	ERE AUTOPSY FINDING: ARLABLE PRIOR TO MPLETION OF CAUSE TOEATH? YES 2 NO NO No Number,

DHMH-16 Rev 1/89

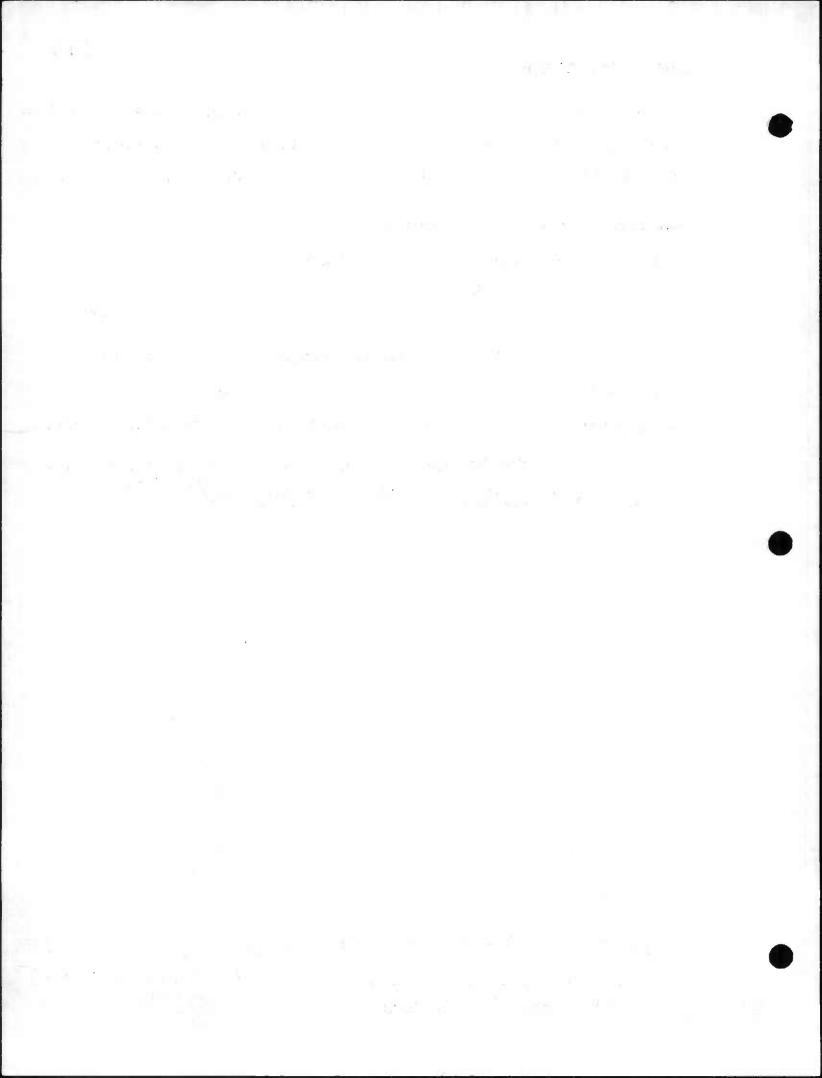
Dr. Myo Thant 9000 Franklin Square Dr. Baltimore, Maryland 21237

31. AVECULAR 1995

June Dr. Myo Thant 9000 Franklin Square Dr. Baltimore, Maryland 21237

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State of Maryland / Department of Health and Mental Hydien 25 38 174

			State of Mary Etem20a,Film730,12/18/95,1t		rtificate of			eg. No.	0177
	Physic	an	Decedent's Nama (First, Middla, Last)				2. Data of Death	Day Year	3. Tima of Death
All I	/Medi		Viola W. Wright				Dec.	16,1995	2:07 pm
	Examir		4a. Facility Name (If not institution, giva street and number)			4b. City, Town, or Lo		4c. County of Death	
1			3204 Dorchester Road			Baltimo	re	Baltimo	re
	Funeral	Г	5. Social Sacurity Number 6. Sex 7. Aga (In	yrs. last birthday)	If Undar 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day,		piaca (State or Foreign intry)
	Director		214-40-5949 ¹□M 2₹F	91 Yrs.	Months Days	Hours Min.	June 1	4,1904-B	alto. MD
	D.		Usual Rasidance of Decedant						42001112
	nylar thow		10a. Stata 10b. County 10	c. City, Town or Lo	cation				10d. Inside City Limits
	a Ma	cto	Maryland n/a	Baltim	ore				Yas 2□No
	th th	Director	10e. Street end Number		10f. Zip Coda		10	g. Citizan of What Cou	intry?
	23a		3204 Dorchester Road		212	15		USA	
	daa fm	Funeral	11 Marital Status 12 Was Decedent Ever	r In U,S. 13. \		dispanic Origin? (Spean, Maxican, Puerto	ecify Yes or No-	14. Race - Amer	
0	świthin 72 hours aftar daath with tha Maryland liene. r than "natural", or itema 23a or 28a-f show the Medical Examinet must be notified at		1 Never Married 2 Married 1 Yas 2 No				Hican, atc.)	Bieck, Whita	, atc.
02	al.	by	3 XWidowed 4 ☐ Divorced If Yes, Give Yeer or Datas:		1□Yes 2ŽNo	Specify:		Specify:	lack
5-0	72 hc	Completed	15. Decedant's Education	16a. Deced	dant's Usuai Occup	pation	1	6b. Kind of Business/li	
21	C 9	pie	(Specify only highast grade completed) Eiamantery/Sacondary (0-12) Collega (1-4or 5+)	lifa. L	DO NOT usa retire	during most of worki	ng		
2	filed with Hygiene. other than	no.	5+	Sc	hool Pri	ncipal		Educatio	n
pu	be filed tal Hygied d other event, ti	Be (17. Fathar's Nama (First, Middia, Last)			18. Mothar's Name	(First, Middla, M	faiden Surnama)	
Maryland 21215-0020	should be and Mental marked o	To	William Wilson			Marv	Thompso	n	
an	2 sho and h ls ma		19a. Informant's Name/Raletionship (Type, Print)	19b. Maiiin	ng Address (Straet	-	-	City or Town, Stata, Z.	ip Code)
Σ	1 and 2 Haalth a em 27 ls		Edgar Powell	5388-	22 Smoo	th Mewdow	Way Co	lumbia, MD	21044
re	ges 1 and 2 should it of Health and Mer if item 27 is marks or other traumatic		20a. Mathod of Disposition 2	Ob. Piaca of Dispo		1	_	Oc. Location - City or T	own, Stata
9	8 5 5 >		1 ☑ Burial 2 ☐ Cramation 3 ☐ Removal from Stata 4 ☐ Donation 5 ☐ Othar (Specify) Encomment				0.1		
Baltimore,	2555		21. Signature of Funaral Sarvice Licensaa	Arbutus	Memorial Nama and Addre				County, MD
Ba	Depa Impo any Ir		11111111			ns Falls	tter Fun Parkwav	eral Homes	, Inc.
	_		Reclient E. Miller	B	altimore	, Marylan	d 21216		
			23a. Part1. Entar the disaasa, or complications that causad tha shock, or heert failure. List only ona causa on aach line.	daath. Do not ente	er tha moda of dyli	ng, such as cardiac o	or raspiratory arre	st,	Approximete Interval Between
	Physician /Medical		In the State Course (First	1 -	11 - 4	4.1		i	Onset and Deeth
	Examiner		Immediata Causa (Final disease or condition rasulting in death)	itive i	176911	791/4	re		20415
		L.		to (or as a consag	uance of):	0	E	1	
	D H	Examiner	a Ather	050	erotic	- (asa	10/95	scalar	00
	The law requires that the death certificata be executed te has been signed by the attending physician and page 2 should be detached for usa as the burial-transit	xan	Sequentially list conditions, if any, laading to immadiate	to for as a conseq	uence of):	diseas	0		35 years
68760,	cian cian buria		Causa, Entar UndartyIng Causa (Disaase or injury			11303			
87	sata Ahysi the	edicai	thet Initiated evants resulting in death) Lest Dua	to (or es e consequ	uence of):				
9 ×	ing p		d.						
Box	as that the death certificated by the attending be detached for usa a	Physician/M	<u> </u>						
o.	e de the a	sic	Pert II. Other significant conditions contributing to death but no	ot resulting in the un	ndarlying causa giv	van in Part I.	23b. Did tol	bacco use contribute	to the cause of death?
P.0	at th	Æ	Atrial Fibrille	ation			1□Ye	s 2.2TNo 3□ Pro	obably 4 Unknown
Ś	as the	þ		(110)					
ב	requir been s	De le					24a. Was en	red?	Vara autopsy findings valleble prior to
ည္	aw re	ple	-				po	C	ompletion of causa I death?
œ	The law ate has page 2	Completed					1□ Ya	s 20 No 1	□Yes 221No
<u>e</u>		BeC	25. Was case referred to medical			26. Placa of Death			2100 22310
>	ysician: ls certifica director,	ToB	axaminar?	2 ER/Outpatien	t 3 DOA Oth	APP.		nca 6 Other (Spec	16.0
0	Physical or this eral or		27. Manner of Death 28e. Data of Injury	28b. Time of	28c. Injur		28d. Dascribe ho		ny)
5	ding it. Th.	5	1 ☑Natural 5 ☐ Panding (Month, Day Year 2 ☐ Accident investigation	ar) Injury		rk? Yas 2 □ No			
Division of Vital Records,	Attending Physician: or death. ector: After this certific by the funeral director,	Certification:	3 Suicida 6 Could not be 288 Place of Injury	At homa, farm, stra	aat, factory, office		28f. Location (Str	eet and Number or Rui	ral Routa Number.
S	after Dire	ert	4 Homicide data milited building, atc. (S)	pecify)	,,,		City or Town,	Stata)	*
Τ.	ours ours filler		29a. Certifier 1 ✓ Certifying Physician: To the best of my	knowledge death	occurred at the tir	ne date and place a	and due to the ce	usa(s) and manner as	etatod
	To the Hospital or Attending Physikinia Abour attended Attended To the Funeral Director: After the completely filled in by the funeral	edical	(Check only one) 2 Medical Examiner: On the basis of axal end menner stated.	mination and/or inv	astigation, in my o	pinion, death occurre	ed at tha tima, da	ta and place, and due	to the cause(s)
	ithin of the office of the off	§	29h Signature and title of certifier		29c, Licens	a number	29	d. Dete signed (Month)	Day, Year)
	r s r ö		Amatun H Nacem	MID	D 1	5502	T	De 18	1995
				***		, ,	- 1	100010	2.110
			30. Name and address of person who completed cause of death BMBTUN NAEEM.	(itam 23a) (Type, I	Tohio	Street	Balt	more. M.	Da1215
					- Control of the Cont		, ,	-),	
	Sta Registr		18 1995	Sideature Randa	W.I				



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

_					State of	rivian			ent of F	Death	mental Hy	rgiene 9	5 3	381	75
	Physic	ian	Decedent's Name (First,	Middle, Li							2. Date of Do		Year		of Death
	/Medi		JOSEPH		M				WILE		DEC	fr	95	4:0	OP.M
3	Exami	ner	4a. Facility Name (If not ins 1927 CASAD			nber)				6b. City, Town, or BALTIM		th 4c. Count			
	Funeral Director		5. Social Security Number		Sex 1⊠XM 2□ F		In yrs. last birth	nday) If Ui Mon	ths Deys	If Under 24 Hrs Hours Min	. (Month, D	19,1945	Cou	intrv)	e or Foreign rginia
	yland how Lat		Usuel Residence of Deced			10	0c. City, Town	or Location						10d. Inside	City Limits
_	28a-f sh notified	ctor	Maryland N	I/A			Baltim	ore						1)() Ye	es 2 No
D	Se or 2	al Director	10e. Street and Number 1927 Cas	adel	Avenue			10f.	Zip Code	1230		10g. Citizen of	What Cou	intry?	He
020	urs after of al', or flems 2 Examiner mu	by Funeral	11. Merital Status 1 Never Married 20 3 Widowed 4 Dh		12. Was Dece Armed For 1 Yes If Yes, Giv Yeer or Da	ces? 2 XNo e	er in U,S.		ecedent of H specify Cuba s 2 XNo	iispanic Origin? (San, Mexican, Puei Specify:	Specify Yes or Note Rican, etc.)	0- 14. Re Bla Specil	ck, White,	ican Indian, , etc. Thite	
Maryland 21215-0020	iwithin 72 ho iene. Than "naturi the Medical I	Completed	(Specify only Elementary/Secondery (ducation ade completed) College (1	-4or 5+)	16a. [Decedent's l Give kind of life. DO NO Labo		ation during most of wo	irking	16b. Kind of B			
d 2	Hygie ther t	ပိ	8th 17. Father's Name (First, N	liddle Les	*1			Labor	rer	18 Mother's Na	me (Eiret Middle	Const	-	TOIL	
lan	名目のる	o Be	11.1 4.10.0 3 144.110 (1 7/3), 11	noure, Las	Jess	Wi	lburn				uie Mar		111		
ary	4 2 E E	70	19a. Informant's Name/Re	lationship	(Type, Print)		19b.	Meiling Add	ress (Street	and Number or R	urai Route Numi	ber, City or Town	State, Zi	o Code)	
	s 1 and 2 in Health ar tem 27 is other trau		James Wil	burn						Avenue		more, M			1230
ore			20a. Method of Disposition		70		20b. Piaca of I	Disposition ((Name of or other plea	(e)	Date	20c. Location	· Clty or T	own, State	
Ĕ	nit. Page partment of ortant: If injury or		1 ☐ Burial 2 🖾 Crem 4 ☐ Donation 5 ☐ Ot			State	Metro				12/15	Baltin	more,	Mary	land
Baltimore,	Depart Depart Import any inj once		21. Signature of Funeral Si	ervice Lice	nsee		0.			ss of Fecility eral Hon		- 1 - 1		010	205
			23a. Part1. Enter the disea	ise, or cor	plications that ca	aused the	e death. Do no	400.	L Ritc mode of dylr	hie High	IWay B c or respiratory a	altimore	e, Ma	Approxim Interval B	
	Physician		SHOCK, OF HEART TEILURE		cause on ea	ach line.							i	Onset an	d Deeth
1	/Medical Examiner		immediate Cause (Final disease or condition		MA	m	os us	none	CAR	MOUASI	MUDIL	nicon	5		
н	CXammer	L	resulting in death)		a. ····································		e to (or as a co					713-1-			
_	tificate be executed g physician and as the burial-transit	Examiner	Sequentially list conditions	ſ	b. ————	Du	e to (or as a co	onsequence	of):		<u> </u>		1		
68760,	ficate be execut physician and the burial-trar	alE	Sequentielly list conditions if any, leading to Immediet cause. Enter Underlying Cause (Disease or Injury that initiated events	` {	C		11								
687	ificate g phys as the	edical	resulting in deeth) Last			Due	e to (or es e co	nsequence	of):						
Box	S di	M			d										
	the attenthed for u	sicia	Part II. Other significant co	enditions o	contributing to de	ath but n	ot resulting in	the undertyi	ng cause giv	en in Pert I.	23b. Did	tobacco use co	entribute t	to the caus	e of death?
P.0	es that the de igned by the be detsched	y Physician/M									1□	Yes 2 No	3□ Pro	bably 4	Udnknown
Records,	requires een sigr hould be	ed by									24a. Was	an autopsy	24b. W	Vere autops	y findings
000	> 0 0	Completed										ormed?	CC	vallable prio ompletion of death?	i cause
	0 - 0	mo:									10	Yes 2□No	1	Yes 2	□ No
of Vital		Bec	25. Was case referred to m	edical						28. Place of De	ath (Check only	one)			
5	Physician: this certific ral director,	10 10	examiner? XIXYes 2 □ No		Hospital: 1 🗆 Ir	patient	2 ER/Outp	atlent 3	DOA Oth	er: 4 Nursing I	Home 5 XRes	idence 6 Oth	ner (Speci	lfy)	
o uoi	After fune			Pending nvestigatio		f Injury n, Day Ye	ear) 28b. Tie	me of ury M	28c. Injur Wor 1 🗆	yat k? Yes 2 □ No	28d. Describe	how Injury occur	rred		
Division	744	Certification:	3 Sulcide 6 □ 0	Could not b letermined	200. Place	of Injury g, etc. (5	- At home, farr Specify)	n, street, fac	ctory, office		28f. Location City or To	(Street and Numi wn, State)	ber or Rur	al Route Nu	ımber,
>	To the Mospital or within 24 hours after To the Funeral Dir completely filled in	edical C	29a. Cartifier 1 Ce (Check only one)	rtifying Pr dicat Exar	nysician: To the i ninar: On the ba and mann	sis of exa	amination and	death occur or investiga	red at the tin	ne, date end place pinion, death occ	a, and due to the urred at the time,	cause(s) and m	anner as s	stated. to the cause	9 (\$)
	o the	Mec	29b. Signature and title of o	artifier	and mann	er stated	•		29c. Licens	e n <i>u</i> mber	1	29d. Dete signe	ed (Month,	Day, Year)
	F 5 → Ö		VICEA S	- N	media	0			_	C M D					
			30. Name and address of p	erson who	completed cause	of death	h (Item 23e) (T	ype, Print)	0.	C.M.E.		DECEMBI	rk I	2,199	30
			MARYDA	(P)	D. 100 RE	TU .	111		n Str	eet, B	altimo	re, Mai	cyla	nd 2	1201
	Sta Registr	_	DEC 18 19	95	ili day	gistrar's	Signature Ardalls								

DHMH-16 Rev 1/89

TO BE COMPLETED BY FUNERAL DIRECTOR

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

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FOR STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

REGISTRAR		CERTIFIC	ATE C	OF DEATH		REG. NO.			
1. DECEDENT'S NAME (First, Middle, Last)						OF DEATH			3. TIME OF DEATH
	Chasta	r O. Wilhe	1 m		Dece	mber 1		995	10pm M
4. SOCIAL SECURITY NUMBER			UNDER 1 YE	AR IF UNDER 24 HRS.	7. DATE	OF BIRTH	-	. BIRTHP	PLACE (State or Foreign
216-05-5452	17 M 2 □ F	86 YRS. MC	ONTHS DAT	YS HOURS MIN.	NO37	6, 190	19	Country;	ryland
9a. FACILITY NAME (If not institution, give s	71	-	h CITY TON	WN OR LOCATION OF DI		0, 170	9c. COUNT		
			_		EATH				
Manor Care Ruxto	on		Towso	n			Ba1	Ltimo	ore
10e. STATE 10b. COUNT	Υ	10c. CITY, T	OWN OR LO	DCATION					10d. INSIDE CITY
1	D 1. *								LIMITS?
Maryland 100. STREET AND NUMBER	Baltimore	T	owson	10f. ZIP CODE			10- 017171		1 YES 2 NO
	a				,				NAI COONTAT?
7001 N. Charles			<u>, </u>	21204			U.S.		
11. MARITAL STATUS 1 Never Married 2 Merried	12. WAS DECEDENT EVER FORCES? 1 YES			DECENDENT OF HISPAI s, specify Cuben, Mexico			or No- 1		- American Indian, White, etc.
3 Widowed 4 Divorced	IF YES, OIVE WAR OR			YES 2 NO Specif				Specify	
*	<u> </u>								White
15. DECEDENT'S EDU (Specify only highest grade	CATION completed)	16e. DECEDENT'S US (Give kind of won	k done during	PATION g most of working	16b	. KIND OF BUS	INESS/INDU	STRY	
Elementary/Secondary (0-12)	College (1-4 or 5+)	life. Do NOT use n	etired.)						
unknown		Tinsmit	h			ailroa			
17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NA			Surname)		
Chester Ovingt	on Wilhelm,	Sr.		Pear	rl Br	own			
19e. INFORMANT'S NAME (Type/Print)		19b. MAILINO AC	ODRESS (Str	reet end Number or Rural	Route Num	ber, City or Town	, State, Zip C	Code)	
Kathleen Phipps	3	18914 M	iddle	town Road	Par	kton.	Mary1	and	21120
20e. METHOD OF DISPOSITION	The state of the s	Db. PLACE AND DATE OF			1		CATION — CI		
Burisi 2 Cremetion 3 Rem		emetery, crematory or other Lake View							
4 Donation 5 Other (Specify) 21, SIGNATURE OF FUNERAL SERVICE LI		Lake view	Memor	Tal rark .	14/19	/42 sy	Kesvi	.TTe	, maryland
21. SIGNATURE OF PUNERAL SERVICE LI	LENSEE /	\cap	A.	Alan Seita	z. Jr	. Fune	ral H	lome	
· a.allo	- Deck.	4							yland 21211
23. PART I. Enter the diseeses, or	complications that cause	ed the deeth. Do not							Approximate
ahock, or heart fellure.	List only one ceuse on								Interval Between
IMMEDIATE CAUSE (Final disease or condition	,	CAPT)						Onset and Death
resulting in death)	a(20 1/2
	DUE TO (OR AS	A CONSEQUENCE OF):							
Sequentially list conditions,	b								
If any, leading to immediate	DUE TO (OR AS	A CONSEQUENCE OF):							
cause. Enter UNDERLYING CAUSE (Disease or Injury	с.								
that initieted eventa	DUE TO (OR AS	A CONSEQUENCE OF):							
resulting in death) LAST	d								
DART II Ober significant condition	no contribution to doot	hut not condition to	Ab	data a sana a strans ta	D. a.l.			Lau	
PART II. Other aignificent condition	na contributing to destri	but not reaulting in	the under	lying cause given in	Part I.	24a. WAS AN PERFOR		24b.	WERE AUTOPSY FINDINGS MAILABLE PRIOR TO
						1 YES 2	160		COMPLETION OF CAUSE OF DEATH?
			10						1 TYES 2 NO
DID TOBACCO USE CONT	RIBUTE TO CAUSE	OF DEATH YES	NO NO	UNCERTAL	N□				
25. WAS CASE REFERRED TO MEDICAL		26. PLACE OF DEATH	(Check only	one)					
EXAMINER?	HOSPITAL:		THER:						
27. MANNER OF DEATH	26e. DATE OF INJURY			Home 5 Residence	1	SCRIBE HOW II	V IIIIW OCCI	IBED	
1 Natural 5 Pending	(Month, Day, Year)		ry	WORK?	26G. DE	SCHIBE HOW II	NJUNY OCCU	JHED	
2 Accident Investigation				YES 2 NO	-				
3 Suicide 8 Could not be	28e. PLACE OF INJUI building, atc. (Sp	RY — At home, term, atre pecify)	et, factory,	office	281, LOC City	or Town, State)	and Number o	or Rural R	oute Number,
4 Homicide determined	11-2-17-								
29e. CERTIFIER 1 CERTIFYING PHYS	SICIAN: To the best of my kno	owledge, death occurred	at the time.	date end piece, end du	e to the ca	use(s) end mer	iner es atate	d.	
(Orioth Ority	IER: On the basis of examinat) and manner as stated.
	- , , ,		. ,						
296. SIGNATURE AND TITLE OF CERTIFIE	" ohleer	MT		29c. LICENSE NU	IMBER		29d. DATE	SIGNED	(Morth, Day, Year)
Joneson,	. 2	リ		1)25	662	-	P (-	768	775
30. NAME AND ADDRESS OF PERSON WI	HO COMPLETED CAUSE OF I	DEATH (ITEM 27) (Type, P	rint)						
13333 N. CAL	VERT ST	STE S	140.	BALT	O. Y.	no.	212	7/5	7
31. DATE FILED (Month, Day, Year)	TR. REGISTRAR PSIC		/		4.1	1 11		- 0	
DEC 1 8 1995	in a mention of	Var							



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DECEMBER, 12, 1995

					5	State o	of Mai	yland				Health and f Death	Mental H	ygiene 9 (5 38	3177
П			1. Decedent's Nam	na (First, Midd	e, Last)								2. Data of D			3. Time of Death
	Physic		LONNI			LLEN							Month	Day	Yeer	
	/Medi — Exami		4a. Fecility Name (Г Р	AIN E	. R	•	4b. City, Town, or BALTIMO			y of Death	0914 AM
	Funeral Director		5. Social Security P		6. Sex 1⊠ M	1 2 F	7. Age 5 6	(In yrs. l	ast birthdey) Yrs.	If U	ndar 1 Yaa ths Deys			Birth Dey, Year)		ce (Stete or Foreign
			Usual Residence of										110-1-	r - 1333	IV.C	•
	how		10a. Stete	10b. County				,	, Town or Lo	ocation					100	d. Inside City Limits
	72 hours efter death with the Maryland naturel, or items 23s or 28s-f show ores Examiner must be notified at	Funeral Director	Md	N/A				Balt	imore							1 ☑ Yes 2 ☐ No
	or 28	Sire	10e. Street and Nu								. Zlp Code			10g. Citizen of		n
	23a or	al	422 Norman	dy Aven	ue						21229			US	A	
	items irer m	ner	11. Marital Status		12.	Was Dece		er In U,S		Was D	ecedent of	Hispanic Origin? (Siban, Mexicen, Puer	pecify Yes or h		ce - American	
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21215-0020		Be Completed	(Spe	15. Deceder cify only highe)		16a. Dece (Give	dent's i	Usual Occu	upetion e during most of wo red)	rking	16b. Kind of E	Business/Indu	stry
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7	hor to	S	9th g		Leath	N/A			Laun	ary	Work			Laund	- ч	
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	1 end Healt rm 2		L1111e 20a. Method of Dis	Norris	5			20h Pi				dy Avenue	Dalti	more, Mo		
Baltimore,	Pages nent of 8 int: If ite		1 Burial 2	Cremetion		noval from	State		ace of Dispo metery, cre					20c. Location		
Ħ	tmer tant:		4 Donetion					Mt	Zion (121695	Lansdo	own, Mo	<u>t</u>
Ba	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hyglene. Important: If flem 27 is marked other than any Injury or other traumatic event, the Magnes.		21. Signature of Fu	Jnarei Sarvice	Licensee	7	for 1	N	22			ress of Facility /H West bash Aven				
	HARRY IN		23a. Parti. Enter t	the disease, or	complicat	tions that c	ceused th	e death	. Do not an	1300 ar the	Ma mode of dv	bash Aven	ue Bal	timore,	Md 21	215 Approximate
	Physician	П	shock, or hea	arl List	only one	cause on e	each line.				,	ying, such as cardia	,		1 10	ntarval Between Onset and Death
	/Medical	Н	Immediate Cause	(Finel		1 1	D1 00		w 00.	0	h 40.					
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9	rtifica ng ph	Med	resulting In death)	Lest						*	•				i	
OX	leath certifica attending pl	l/Jue			d											-
B.	a death the atter hed for u	Physician/Med	Part II. Other signif	ficant condition	ns contrib	outing to de	eath but	not resu	Iting In the u	nderlyi	ng cause g	iven in Pert I.	23b. Di	d tobacco usa co	ontribute to t	he cause of death?
P.0	5 > 2	h											10	Yes 2 No	3 Probe	bly 4 thknow
		b														
Records,	v requires been sign should be													is an eutopsy formad?	24b. Wers	a autopsy findings abla prior to
900	aw Is b	Completed													com	pletion of ceuse eth?
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Jo L			27. Manner of Deet		. 2	28a. Date (Mont	of Injury	(ear)	28b. Time o	f	28c. Inj			how injury occu		
<u>Ö</u>	Attending in death.	atic	2 Accident	5 Pendin investig	gation		,,		,,	M		Yes 2 No				
Division	De Co	Certification:	3 Suicide 4 Homicide	6 Could determ		28e. Place buildi	of Injury	- At hor	ne, ferm, sti	eet, fa	ctory, office	÷		(Street end Num.	ber or Rural F	Route Number,
۵		Ce				- 411411		,								
	To the Hospital within 24 hours To the Funeral completely filled	edicai	29a. Certifiar (Check only	1 Certifyin	g Physicia	an: To the	best of r	ny know	ledge, death	occur	red at the t	time, date and place opinion, death occu	, and due to th	e ceuse(s) end m	anner as stat	ed.
	at de		one)			and manr	ner stete	d.	on anaron m	- ooriga			ou at the tillit			
	With To To	Σ	29b. Signature and	titla of certifia	,	A .					29c. Licar	nsa number	_	29d. Data signe	ed (Month, Da	ıy, Year)

HARYMAN D. WOREL HM.

31. Date filed (Month, Day, Year)

DEC 1 6 1995

Audit State

111 Penn Street, Baltimore, Maryland 21201 32. Registrar's Signature

and address of person who completed ceuse of deeth (Item 23a) (Type, Print)

Lin Save son Rardall

O.C.M.E

Registrar

water a see a constant

TO BE COMPLETED BY FUNERAL DIRECTOR

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed whem 24 hours after death. Page 6 may be retained by the hospital or attending physician,	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burlal-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burlal, cremation, or removal.	IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.	
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- STATE REGISTRAR				CERT	IFICAL	IL OF	DEATH		REG. NO.			
1. DECEOENT'S NAME (First	, Middle, Last)	A 0	Λ	- /					ATE OF DEATH	/A	YEAR	3. TIME OF OEATH
Helev	2	Hexan	200	27 ·				"	2 10	6	95	· 4AM
4. SOCIAL SECURITY NUM	BER	5. SEX	6. AGE (In yrs. lest birth		DER 1 YEAR	IF UNDER 24 HRS.		ATE OF BIRTH Aorth, Day, Year)		8. BIRTH Country	PLACE (State or Foreign
212-35	29840	1 🗆 M 2 🗡 F	5	8 v	RS. MONTH	8 DAYS	HOURS MIN.		n.31,1	937	Court	"VA
9a. FACILITY NAME (# not h	nstitution, give s	treet and number)			9b. CI	TY, TOWN	OR LOCATION OF	_			NTY OF O	EATH
Bons Sec	ours	Hospita	1			Ba	ltimor	е			N	/A
RESIDENCE OF DEC												
IOa. STATE	10b. COUNT			100	. CITY, TOWN				_			10d. INSIDE CITY LIMITS?
MD	n	/a		_]	Balt	imore					1 XXES 2 NO
00. STREET AND NUMBER	Y.	4. 4.				101	ZIP CODE			10g. CIT	IZEN OF W	THAT COUNTRY?
410 W. Fr	ankli	n St.					21201				Ü	SA
11. MARITAL STATUS		12. WAS DECEDER	IT EVER IN	U.S. ARMED	1				RIGIN? (Specify Yes	or No-		- American Indian,
Never Married 2		FORCES?					ecify Cuban, Max		erto Rican, atc.)		Black Speci	r, White, atc.
Widowed 4 XXX	orced						- 197	,				Black
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Elementary/Secondary (College (1-4 or 5	+)	life. Do I	IOT use retired	d.)	ist of working					
12th				Nu	rse				Priv	ate	Nur	sing
17. FATHER'S NAME (First, A									irst, Middle, Maiden	Surname)		
Theodore	Will	iams					En	nie	Wildy			
9a. INFORMANT'S NAME (Type/Print)			19b, MA	ILING ADDRE	ESS (Street a	and Number or Run	n/ Aoute	Number, City or Tow	n. Stata. Zi	o Gode)	
JoAnna B1	ount											1to.MD 21
20a. METHOD OF DISPOSIT		ovet from State		PLACE AND D			arne of		DATE 20c. LO	CATION —	City or To	wn, Sieta
Donation 5 🗆 Other				Arbut	115 M	emor	ial Pk	. 1	2/21	BALT	OMT	RE, Md
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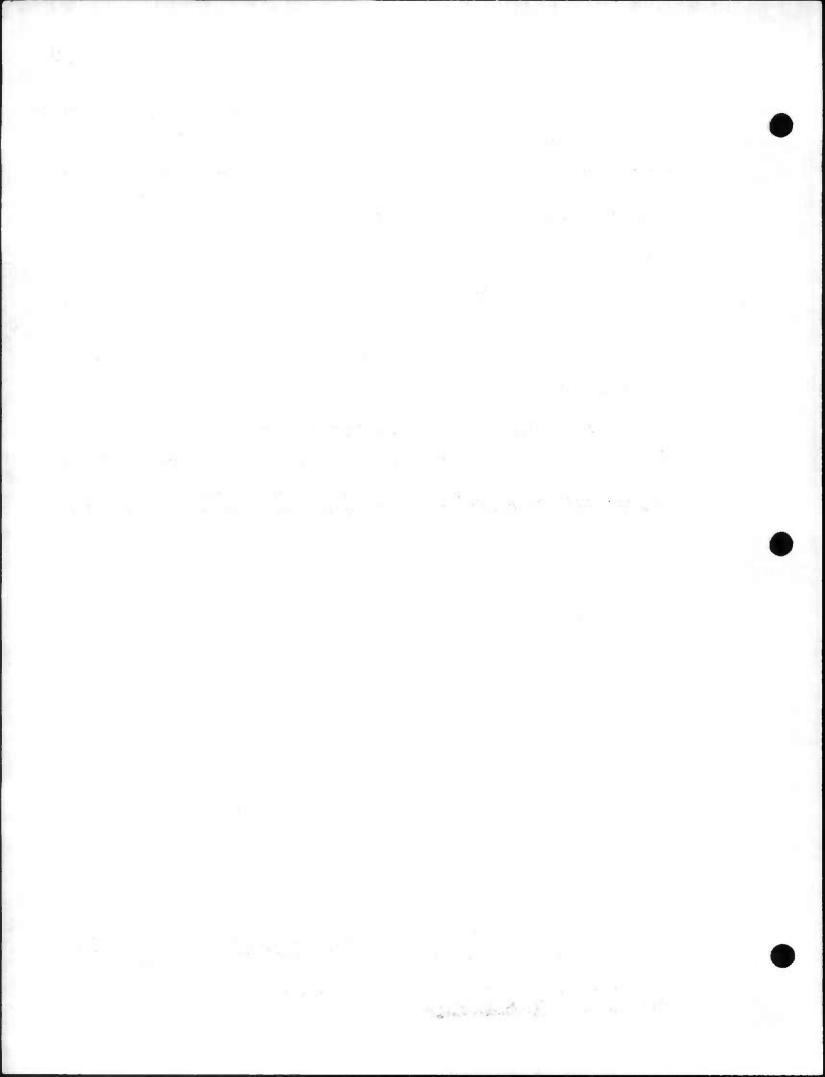


32. REGISTRAR'S SIGNATURE

Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible.

State of Maryland / Department of Health and Mental Hygien 95 38 179

			Certificate of Death Reg. No.									
	B	- 1	1. Decedent's Name (First, Middle, Las	Donald Adams				2. Date of Do	eath	Vaar	3. Time of Death	
	Physici /Medi			Donato Adams	5			Decemb	er 17,	1995	8:00am	
	Examir		4a. Facility Neme (If not institution, give street and number) 4b. C					b. City, Town, or Location of Death				
			2102 Cypress Dri	ve			Bel Air Harford					
	Funeral		5. Social Security Number 6. S		last birthday)	If Under 1 Yee			irth 9. Birthplece (Stete or Fore Country)		lece (Stete or Foreign	
	Director		215-10-5177 X	X ^{M 2□ F} 83	Yrs.	Working Doys	Tiodis Iviii.	May 5	(Month, Dey, Year) May 5, 1912 Balto, MD			
	D		Usuel Residence of Decedent 10e. State 10b. County	100 Cib	y, Town or Lo							
	anyla show	Director	Maryland Harfor	_		air				1	0d. inside City Limits 1 ☐ Yas ※No	
	Ne N		10e. Street and Number					1				
	with or		10e. Street and Number 2102 Cypress Drive 21015						10g. Citizen of			
	m 23	eral	2102 Cypress Drive 210 11. Marital Stetus 12. Was Decedent Ever In U.S. 13. Was Decedent of Hispanic O					nacify Vac as N		J.S.A.		
_	Herr d	To Be Completed by Funeral	11. Marital Stetus 1 Never Married 2 Married	Armed Forces?	3. 13. V	Yes, specify Cu	Hispanic Origin? (S ben, Mexicen, Puert	o Ricen, etc.)	Bie	ck, White,		
320	irs af		₩Widowed 4 Divorced	If Yes, Give	1 ☐ Yes 2 X No Specify:				Specify: white			
0	2 hou					16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)				16b. Kind of Business/Industry		
215	n n		(Specify only highest gre Elementary/Secondery (0-12)	de completed)	(Give life. L	kind of work done OO NOT use retir	e during most of wored)	rking			,	
21	d with		12+	College (1-4or 5+)		Checke:	r		Steams	nip T	rade	
pu	事		17. Fether's Neme (First, Middle, Last)				18. Mother's Nar	ne (First, Middle	, Melden Sume	ne)		
<u>la</u>	Aents Aents Treed tice		Frank C. Adams				G	race H	race Hucts			
an	sm s		19e. Informant'a Name/Reletionship (7	ype, Print)	19b. Mallin	g Address (Stree	et end Number or Ru	irel Route Numb	oer, City or Town	, State, Zip	Code)	
Σ	permit. Pages 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notitled at once.		Donna Peabody D	aughter	210	2 Cypred	dd Drive	Bel Ai	r, MD 2	015		
ore	of He		20a. Method of Disposition	20b. P	lace of Disposemetery, crem	sition (Neme of netory or other pl	dd Drive	Date	20c. Location	- City or To	wn, State	
Ē	Page nent int: If		15 Purial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify	Hemoval from State		Park Cer		12/19	Woodlav	vn, Ma	aryland	
at	Departi Importa any Injo		21. Signature of Funeral Service Licen	100	22	Name and Add	ress of Fecility					
Ф	88 5 8		Burgee-Henss Funeral Home 3631 Falls Road Baltimore, Maryland 23e. Pert1. Enter the proposes, or compilications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, Maryland Approximate Interval Between Interval Betwe									
		Examiner	23e. Pert1. Enter the or wese, or comp	ollcations that ceused the death	n. Do not ente	31 Fall: or the mode of dy	S Road B	altimor	e Mary	and ?	21211 Approximate	
ы	Physician		SHOCK, OF HEAR COMMEN. LIST OFFICE	one cause on each line.							Interval Between Onset and Death	
ч	/Medicai		Immediate Cause (Finel disease or condition	()		(0,	n. I of					
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	ertificate be assecuted ing physician and e as the burial-transit		Sequentially list conditions,	Due to (or	r as a consequ	uence of):	1	000		1	Jan	
ó	e axe	m	Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Cause (Disease or Injury	10.100		of in	a d	seal	20	i	4 your	
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99	ntifica ng pl	Mec	Tooking in Journ Last									
Bo	attendi	Certification: To Be Completed by Physician/		d						1		
- 4	that the death cert ed by the attendin detached for use		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					23b. Dtd	23b. Dtd tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings aveilable prior to			
9	at the							1□				
Vital Records, P.O	w requires that been signed should be def											
oro	pluor							24a. Was				
e C	The lar								completion of cause of death?			
E.								10	Yes 2 No	10	Yes 2□ No	
ita	Attending Physician: The or death. actor: After this certificate by the funeral director, peg		25. Was case referred to medical examiner?				28. Place of Dee	oth (Check only	one)			
	physic this ce		1 ☐ Yes 2 No		ER/Outpatient	3LI DUA	ther: 4 Nursing H	lome 5 Res	idence 6 □Ot	dence 6 Other (Specify)		
Division of	ding Ph h. After thi funeral		27. Manner of Deeth 1 Naturel 5 ☐ Pending	28e. Date of Injury (Month, Dey Year)	28b. Time of Injury	28c. Inju	ury at ork?	at 28d. Describe how injury occurred				
sio	deeth. ctor: A y the fu		2 Accident Investigation		M 1 Yes 2 No							
Ž	of or Attended of the office o		3 Suicide 6 Could not be determined	28e. Plece of Injury - At ho building, etc. (Specify	28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify)				28f. Location (Street end Number or Rural Route Number, City or Town, Stete)			
Ω	ttal o											
	To the Hospital or Attending I within 24 hours efter deeth. To the Funeral Director: After completely filled in by the funeral process.	Medical	(Check only 2 Medicat Exam	etcian: To the best of my know Iner: On the basis of examinat	vledge, deeth lon and/or inv	occurred at the testigation, in my	time, date and place opinion, death occu	, and due to the rred at the time,	cause(s) and m date and place,	anner as st	tated. the cause(s)	
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	10		1 2 1000 0 10 95							140		
			30. Name and address of person who c	Comment of the commen					1			
			Dr. Jerald Ins	el 5601 Loch F	Raven E	BLvd.	21239					
	Sta Registr	_	31. DEC 109 1995")	his waser hards	4							



TO BE COMPLETED BY FUNERAL DIRECTOR

TO THE MOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the host	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detache	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
n certificat	nding phy	Hygiene p	or other
nat the death	by the atte	and Mental	ny Injury, o
v requires t	been signed	f. of Health	shows a
N. The lan	ficate has	State Dep	r Item 23
PHYSICI/	r this cert	h with the	arked, o
TENDING	TOR: Afte	after deat	28 Is m
AL DR AT	AL DIREC	72 hours	If item
TO THE HOSPIT	TO THE FUNER.	be filed within .	IMPORTANT:

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

MARY G. ALBERT 3. SEX ALGE (Pr. N. BERGET) SEX ALGE (Pr. N. BERGET) SEX ALGE (PR. N. BERGET) SE							95	38180
MARY G. ALBERT 3. SEX ALGE (Pr. N. BERGET) SEX ALGE (Pr. N. BERGET) SEX ALGE (PR. N. BERGET) SE	. STATE	STATE OF MAR					E	
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HOSPITAL: 1 Inpetiant 2 ER/Outpetiant 3 DOA A Nursing Homa 5 Residence 8 Other (Specify) MANNER OF DEATH 1 Natural 5 Pending Investigation 3 DOA A Nursing Homa 5 Residence 8 Other (Specify) MORY AT WORK? A DESCRIBE HOW INJURY OCCURED No Natural 5 Pending Investigation 3 DOA A Nursing Homa 5 Residence 8 Other (Specify) 28a. DATE OF INJURY DATE DATE OF INJURY AT DATE	DID TOBACCO USE CONT	TRIBUTE TO CAUS	E OF DEATH YE	ES NO [UNCERTAI	 N		1 YES 2 NO
MANNER OF DEATH Sala Date Of INJURY (Month, Day, Year) 28a. TIME OF INJURY AT WORK? 1 YES 2 NO 1 YES 2 NO 28a. DATE OF INJURY AT WORK? 1 YES 2 NO	EXAMINEB?			OTHER:		8 Other (Specific)		
2 Accident 3 Suicide 4 Homicide 5 Could not be datarmined 28a. PLACE OF INJURY — At home, larm, streel, lactory, office 5 building, atc. (Specify) 28a. PLACE OF INJURY — At home, larm, streel, lactory, office 6 City or Town, State) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 282. PLACE OF INJURY — At home, larm, streel, lactory, office City or Town, State) 283. LOCATION (Street and Number or Rural Route Number, City or Town, State) 284. LOCATION (Street and Number or Rural Route Number, City or Town, State)	MANNER OF DEATH 1 Netural 5 Pending	28a. DATE OF INJ (Month, Day, Y	URY 28b. TIM	IE OF 28c. IN	NJURY AT YORK?		NURY OCCURED	
(Check only one) 2 Martical EXAMINER: On the basis of axamination and/or investigation, in my opinion, death occurred at the lime, data and place, and due to the cause(s) and manner as stated.	3 Suicide 8 Could not be	28s. PLACE OF IN	JURY — At home, larm, (Specify)			281. LOCATION (Street a City or Town, State)	and Number or Bur	ral Route Number,
2 The Title Committee: On the basis of axamination and/or investigation, in my opinion, death occurred at the lime, data and place, and due to the cause(a) and manner as stated.	(Check only							
29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year)	BIGNATURE AND TITLE OF CENTIFIE		metion and/or investigation	on, in my opinion,				

 BALTIMORE, MARYLAND 21215-0020

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, P.O. BOX 68760

	12. 10. 12. 2 700 12/13/30 010	
FOR STATE	STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL H	IYGIENE
REGISTRAR	CERTIFICATE OF DEATH	REG. NO.

REGISTRAR		CERTIFI	CATE O	F DEATH		REG. NO.				
DECEDENT'S NAME (First, Middle, Lest)		4 - 4 - 5 -					y YE	3. TIME OF DEATH		
Gene Byingt	DOROTHY	Y JEANNE BYING	GTON							
	5. SEX 6. /	AGE (In yrs. last birthday) 55 YRS.			7, DATE (16		BIRTHPLACE (State or Foreign Country) shington, D.(
a. FACILITY NAME (If not institution, give at	treet and number)		9b. CITY, TOW	N OR LOCATION OF D	EATH		9c. COUNTY	OF DEATH		
Mercy Medical	Center		Balti	more			N/A			
E. Tonit	1			CATION				10d. INSIDE CITY LIMITS? 1 YES 2 NO		
	Apt. 307			101. ZIP CODE 21202			-	of what country? States		
☐ Never Married 2 ☐ Married	FORCES? 1	YES 2 NO	If yes	specify Cuban, Mexic	an, Puerto F			RACE — American Indian, Black, White, atc. Specify: White		
Elementary/Secondary (0-12)	College (1-4 or 5+)	life. Do NOT us	e retired.)	most of working						
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5 +) 1										
17. FATHER'S NAME (First, Middle, Lest) 18. MOTHER'S NAME (First, Middle, Melden Surneme)										
George Charles Clarke Louise Alter										
						ber, City or Town	n, State, Zip Coo	de)		
								en en la company		
4 Donation 6 Other (Specify) ROCK Creek Cemetery 12/18 Washington, D.C.										
John O. Mitchell IV Order A Mitchell TO Order A M										
23 MAT I Enter the diseases or	complications that as	weed the deeth. Do n	Balt	Imore. MD	2.12.	12		Approximate		
MMEDIATE CAUSE (Final disease or condition resulting in death)	a. HUPOXI	AS A CONSEQUENCE OF						Interval Betwee		
cause. Enter UNDERLYING CAUSE (Disesse or injury that initiated events	· Chronic	Alcoho	0A /c	erse		3				
PART II. Other significant condition	e contributing to de	ath but not resulting i	in the underi	ying cause given i	n Part I.	PERFOR	IMED?	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?		
DID TORACCO LISE CONT	PIRLITE TO CALLS	SE OF DEATH YE	SINO	LINCERTA	IN 🖂		-	1 TYES 2 NO		
	RIBOTE TO CAUS									
EXAMINER?	HOSPITAL:	3/Outpetlent 3 □ DOA	OTHER:	Mome & Decidence	s □ Othe	r (Snaoihi)				
	28a. DATE OF INJ	JURY 286. TIM	E OF 28c	INJURY AT WORK?			NJURY OCCUR	ED		
Accident Investigation Suicide Could not be								Rural Route Number,		
A. ACETTICE										
(Check only								ause(a) and menner as stated.		
HIL SIGNATURE AND MILE OF CENTIFIE	o Tana	100		20191	26	- 3	D Dog	IGNED (Month, Day, Year)		
Charles Joseph	TOUCE OF	OF DEATH (ITEM 27) (Type	Print)	Dley Dri	14 Be	Atrus	ne, m	n 51558		
11. DATE FILED (Month, Day, Year)	- 43									
	DECEDENT'S NAME (First, Middle, Last) SOCIAL SECURITY NUMBER 0.54-38-0102 10. SOCIAL SECURITY NUMBER 0.54-38-0102 10. STATE	DOROTH DOROTH DOROTH DOSCIAL SECURITY NUMBER DOSCIAL SECURITY NUMBER DOSCIAL SECURITY NUMBER DOSCIAL SECURITY NUMBER DOSCIAL SECURITY NUMBER DOSCIAL SECURITY NAME (if not institution, give street and number) DOSCIAL SECURITY NAME (if not institution, give street and number) DOSCIAL SECURITY NAME (if not institution, give street and number) DOSCIAL SECURITY NAME (if not institution, give street and number) DOSCIAL SECURITY NAME (if not institution, give street and number) DOSCIAL SECURITY NAME (if not institution, give street and number) DOSCIAL SECURITY NAME (if not institution, give street and number) DOSCIAL SECURITY NAME (if not institution, give street and number) DOSCIAL SECURITY NAME (if not institution, give street and number) DOSCIAL SECURITY NAME (if not institution, give street and number) DOSCIAL SECURITY NAME (if not institution, give street and number) DOSCIAL SECURITY NAME (if not institution, give street and number) DOSCIAL SECURITY NAME (if not institution, give street and number) DOSCIAL SECURITY NAME (if not institution, give street and number) DOSCIAL SECURITY NAME (if not institution, give street and number) DOSCIAL SECURITY NAME (if not institution, give street and number) DOSCIAL SECURITY NAME (if not institution, give street and number) DOSCIAL SECURITY SECURITY NAME (if not institution, give street and number) DOSCIAL SECURITY NAME (if not institution, give street and number) DOSCIAL SECURITY NAME (if not institution, give street and number) DOSCIAL SECURITY NAME (if not institution, give street and number) DOSCIAL SECURITY NAME (if not institution, give street and number) DOSCIAL SECURITY NAME (if not institution, give street and number) DOSCIAL SECURITY NAME (if not institution, give street and number) DOSCIAL SECURITY NAME (if not institution, give street and number) DOSCIAL SECURITY NAME (if not institution, give street and number) DOSCIAL SECURITY NAME (if not institution, give street and number) DOSCIAL SECURITY NAME (if not institution, give stre	DOROTHY JEANNE BYIN SOCIAL SECURITY NUMBER 5. 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me file date than

95-7659-510

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Item18 12-19-95 FilmG730 W.H.Per F/H Item4a

State of Maryland / Department of Health and Mental Hygiene

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U	U		0	-	

Physician
/Medical

Certificate of Death

Examine

Funeral Director

28a-f show 'natural', or Herns 23a or

Pages 1 and 2 should be filed within 72 hours after continent of Health and Mental Hygierm Important: If Item 27 is marked other than eny injury or other traumatic averages.

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

To the Hospital or Attanding Physician: The law requires that the death certificate be executed within 24 hours after death.

You the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician/Medical

Be Completed by

10

Medical Certification:

Division of Vital Records, P.O. Box 68760.

	1. Decedent's Nem	e (First, Middl	le, Last)										2. Date of D	eath	_	24110-	3. Time of Dea	th
an	ROBERT		0.						В	JRCH	ł		Month DEC		Day 15	Yeer 9.5	2:47P.I	М.
al er	4a. Fecility Name (f not institution	n give street end nu	ımber)						4b. City	, To	wn, or Lo	cation of Dee	th		y of Deeth		
	3900 bl	k.deli	av	е						BAI	T.	IMOI	RE		N/A			
	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Dete of Months Days Hours Min. (Month, (Mo										8. Dete of B Month, C NOV	irth	(ear)	piace (State or For	reign			
	078-01-7	639 A	10 M 20 F	84	1	1	rs.	WOULTS	Days	1100	113	TWITT.	Nov 4	3	1911	COL		
	Usuel Residence of Decedent														N/C			
	10a. State	10b. County			10c. City	, Town	or Loca	ation								5	10d. Inside City Lir	
tot	Md N/A Baltimore												XX Yes 2	No				
irec	10e. Street and Nur	mber						10f. Zip	Code					100	. Citizen of	What Cou	intry?	
alD	3802 P	enhurs	t Avenue					21	215						US	Α		
ned	Md N/A Baltimore 10e. Street and Number 3802 Penhurst Avenue 11. Marital Stetus 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6 th grade 17. Father's Neme (First, Middle, Last) Otey Burch 10f. Zip Code 21215 13. Was Decedent of Hispanic Origin? (Specify Yes If Yes, specify Cuben, Mexican, Puerto Rican, et If Yes, specify Cuben, Mexican, et If Yes, specify Cuben, Mexican, e								ecify Yes or N	0-		ce - Amer	can Indian,					
ď									1110011, 010.7									
įρ	3 Widowed	4 Divorced	W Yearlol	Dates:			''	_ 165	polyd 140	, spe	uny.				Speci	Specify: Black		
etec	(Spec	15. Deceden	t'a Education st grade completed;)		16a.	Decede (Give ki	nt's Usua ind of wo O NOT us	al Occu	pation during	mosi	t of work	ing	16	6b. Kind of E	Business/I	ndustry	
μ	Elementary/Secondary (0-12) College (1-4or 5+)							se retin	ed)									
Ö	6th grade N/A Ta					ilo	r		,					Clot	9			
Be	17. Father's Neme		Last)							18. M	lothe	r's Name	e (First, Middle	e, Ma	iden Suma	me)		
2	Otey Bu	rcn				,					Ne	llie	-Sunst	NEW PROPERTY.	Dun	ston		
	19e. Informant's Na	ame/Relations	hip (Type, Print)			19b.	Mailing	Address	(Stree				al Route Num			, State, Zi	p Code)	
	Florence	M. Bui	rch			3	802	Pen	hur	st A	۷e	nue	Balto	,	Md 21	215		
	20a. Method of Disp				20b. PI	ace of	Disposi	tion (Nar	ne of	acel			Dete	20	c. Location	- City or T	own, Stete	
	1 XIXBurial 2 I 4 □ Donation		3 □Removal from pecify)	State	Mg	Na	t M	emor	ial	Par	k	1	.22095		Laure	1, Md		
	21. Signature of Fu	neral Service	Licensed /				22.	Neme en	d Addr	ess of Fa	acilit	ty						
	MIG	10me	H.J)m	PSU	2		Marc				St	nue B	al	to. M	d 212	15	
	23e. Part1, Eater ti shock, or hea	he disease, or rt failure. Llat	complications that only one cause on	caused each line	the death	. Do n	ot enter	the mod	e of dy	ing, such	n as	cardiac o	or respiratory	arres	1,		Approximete Interval Between Onset and Death	1
	Immediete Cause (disease or conditio resulting in death)	(Final n	· AA	en	osci	en	shi	2 (B.V	elic	SVS	Ju	low	l) is ea	se		
10					Oue to (or	as a c	onsequ	ence of):										
- Pi			b															
xaminer				Sequentially list conditions, Due to (or as a consequence of):														

cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest

Due to (or es e consequence of):

Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? Unknown 1 Yes 2 No 3 Probably

24a. Was an autopsy performed?

24b. Were autopsy findings available prior to completion of cause of death?

2 No

2 No

25. Was case referred to medical XXYes 2□ No

28a. Date of Injury (Month, Day Year) 5 Pending investigation

1 ☐ inpatient 2 ☐ ER/Outpatient 28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 8 Other (Specify) SCENE 3□ DOA 28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28. Place of Deeth (Check only one)

28d. Describe how Injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

29b. 5jó

27. Menner of Death

1 Natural 2 Accident

3 Sulcide

4 Homicide

JD Certifying Physician: To the best of my knowledge, death occurred at the time, date and piece, and due to the ceuse(s) end menner es stated.

ZMMedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and piace, and due to the ceuse(s) and menner stated.

6 Could not be determined

29c. License number

29d. Date signed (Month, Day, Year)

death (Nem 23a) (Type, Print)
111 Penn Street, Baltimore, Maryland 21201

O.C.M.E.

DECEMBER 16,1995

State Registrar

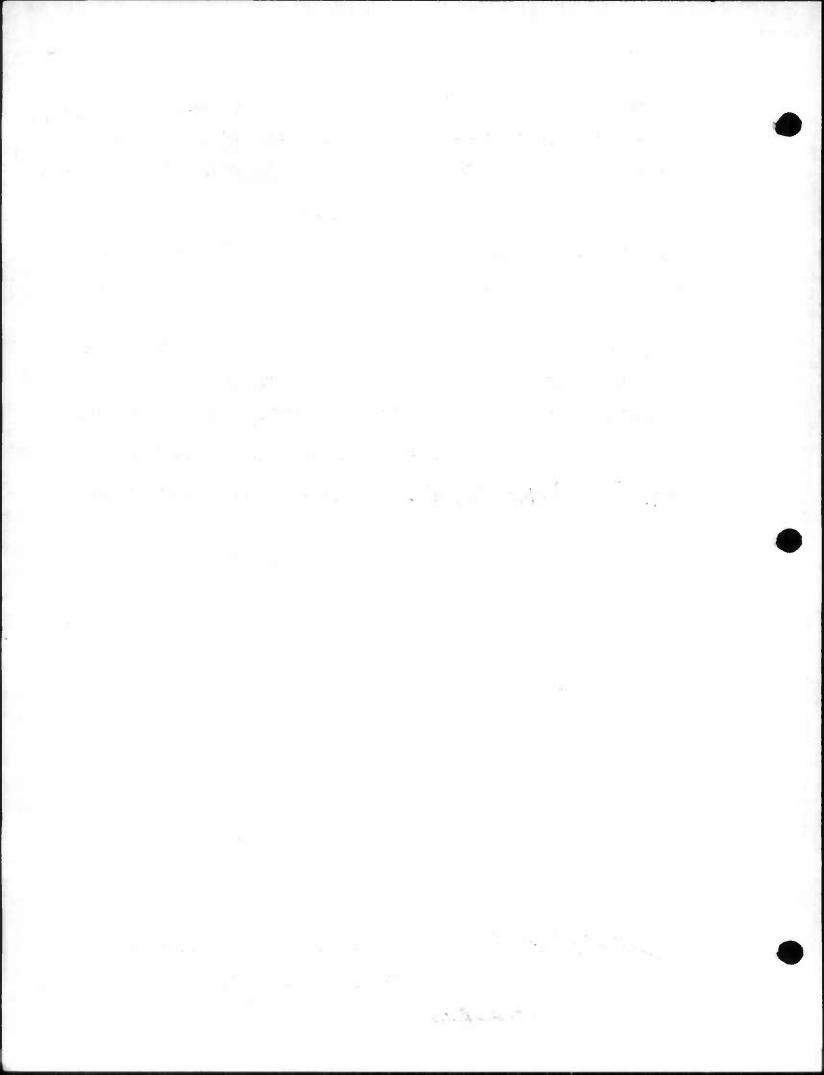
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Solventia (S. 1986) in North Control (1987) in the Control (1987)

Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible.
State of Maryland / Department of Health and Mental Hygiene 95 38 | 83

				J.	Ce	ertificate of	Death		Reg. No.		
	Ohusial		1. Decedent's Neme (First, Middle, La					2. Dete of De	eth	Yeer	3. Time of Death
	Physici /Medi		tammie	poi	yd			DEC. 1	4,1995	1001	12/14
3	Examir		4e. Feclity Neme (If not institution, giv		-T		4b. City, Town, or L BALTIMORE	CITY		of Deeth	11:30pm
				VERT STRE		If Under 1 Yea					
	Funeral Director		5. Social Security Number 6. S 212-86-6442 Usuel Residence of Decedent	ox 7. Age (in 35)	yrs. lest birthdey Yrs.	Months Day		8. Dete of Bir	, 1960	9. Birthp	piece (Stete or Foreign MORE, MD
	fand w		10a. Stete 10b. County	100	. City, Town or L	ocation				1	0d. Inside City Limits
	Many	tor	MD n/a			BAL	TIMORE				1XYes 2□No
	or 28	Director	10e. Street end Number			10f. Zip Code	01000		10g. Citizen of W		
	ath w	rai	1625 N. CALVE	RT STREET 12. Wes Decedent Ever			21202		UNITED		TES
020	permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health end Mentel Hyglene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show important: if item 27 is marked other than "natural", or items 23a or 28a-f show important: or other traumatic event, the Medical Examinar must be notified at adds.	by Funeral	11. Maritei Stetus XIX Never Merried 2 Merried 3 Widowed 4 Divorced	ecify Yes or No Rican, etc.)	Specify:	k, White,	ean Indien, etc. ACK				
2-0	72 ho natur	pete	15. Decedent's Ed (Specify only highest gra	fucation		edent's Usuel Occi	upetion e during most of work	ina	16b. Kind of Bus	sinass/In	dustry
121	of hen	Completed	Elementery/Secondery (0-12)	Coilege (1-4or 5+)	life.	DO NOT use retir ABORER	ed)		FOOD	SED	VICE
d 2	Hygie ther t	ပိ	12 th	-	L	ABUKLK	18. Mother's Nem	e (First, Middle			VICE
lan	lentel ked o ked o lic evi	To Be	WALTER BOY					ELLÄ	BRICE		
Mary	end 2 shou eaith end N n 27 is mar		19e. Informant's Neme/Reletionship (SYDELLA BOY	Туре, Print) D	19b. Mail	ing Address (Stree	et end Number or Rui CALVERT S	T., BA	LTIMORE,	State, Zip	21202
Baltimore, Maryland 21215-0020	Pages 1 e nent of Hea int: If Item ury or othe		20e. Method of Disposition 1 🗆 9/uriei 2 □ Crametion 3 □ 4 □ Donetion 5 □ Other (Specification of the content of the conten	Removei from Stete		osition (Nama of emetory or other pi ON CEME	PERY 12-2	Dete 0	20c. Location - 0		
alti	permit. Pag Department Important: I any injury c		21. Signeture of Funerel Service Licer		2	2. Neme end Add	ress of Fecility				
0	88 3 68		7. Valencia	Hollas	rd 1	WM. C. M	ARCH FH1	101 E.	NORTH	AVEN	NUE
			23a. Part 1. Entar tha diseese, or com shock, or heert failure. List only	plications that caused the one cause on each line.	death. Do not an	ntar the mode of d	ring, such es cardiec	or respiretory e	errest,		Approximete tntervel Between
H	Physician /Medical		tmmediete Causa (Final	0 -	-						Onset and Deeth
	Examiner		diseese or condition resulting in daeth)	· Perito	to (or es e conse						months
	D =	ner		Perfora		Cecur	n			1	months
	and -trans	Examiner	Sequentially list conditions,		to (or es e conse	1					
68760,	be ex ician buriel		Sequentielly list conditions, if eny, laading to immediate cause. Enter Underlying Ceuse (Oiseesa or Injury that initiated events	C.	Tage		25				Years
	wificete be executed ing physician and a as the buriel-transit	Medical	resulting in deeth) Last		o (or es e conse	quence of):					
Вох	eeth cer attendin I for use	Physician/		d							
P.O.	that the de ed by the a detached i	ysic	Pert II. Other eignificant conditions of	ontributing to deeth but not	resulting in the	underlying cause (iven in Pert I.		10		the cause of death?
	as that igned b	by Pi						1	Yee 2/2/No	3 Pro	bably 4 ☐ Unknown
Records,	been should	Completed t							an eutopsy ormed?	ev	ere autopsy findings ellable prior to mpletion of cause death?
	The lew ate hes page 2	E OC						10	Yes 2XXNo	10	☐ Yes 2 No
/ita	iclan: The b certificate he rector, page	Be (25. Wes casa referred to medical exeminer?				28. Place of Deal	h (Check only	one)		
of	Physics this ca	7	1 Yes 2√No		2 ER/Outpatie	INT 3LI DOA		1437	denca 6 Othe		(y)
uo O	tending Ph leath. for: After th the funeral	tion	27. Manner of Deeth X Naturel 5 Panding invastigation	28a. Dete of Injury (Month, Dey Yea	28b. Time (Injury	W	ury et ork? ☐ Yes 2 ☐ No	26d. Describe	how Injury occurre	bd	
Division of Vital	2005	Certification:	2 Accident invastigation 3 Suicide 6 Could not be 4 Homicide		At home, ferm, st ecify)			26f. Location (City or To	Street end Numbe wn, Steta)	or Aura	al Route Number,
	To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b		29a. Certifiar 1XXCertifying Ph	ysictan: To the best of my	knowledge, deel	th occurred et tha	tima, data end place,	and due to tha	causa(s) and mer	nner es s	teted.
	the Ho in 24 the Fu	edical	(Check only one) 2 Medical Exam	niner: On the basis of examend manner steted.	ninetion end/or Ir	nvestigation, in my	opinion, deeth occur	red et the time,	dete end plece, •	nd due to	the cause(s)
	To t com	Σ	29b. Signeture end title of certifiar	11			nse number		29d. Date signed	(Month,	Day, Year)
	7		1111	1//			19129		Dec /	5,	1995
	1		30. Name and addrass of person who	complated cause of deeth		Print)	l Place	RT	- Mnm	Mi	21202
	Sta Registr	11	31. Date filed (Month, Dev. Year)	32. Registrer's S	igneture	- 100	i lace	O. I	THOTE	, -()	41000
	3.5.		.555	· ··· IN THE BUILDING	TALE						



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

38184 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Tima of Deeth Month **Physician** BECKER RODIL DEC PR5 10.15 PM /Medical 4e. Fecility Name (If not institution, giva street end number) 4b. City, Town, or Location of Deeth 4c. County of Death **Examiner** FRANKLIN HOME If Under 1 Year Months Days NURSING W0005 BALTIMORE If Undar 24 Hrs. Hours Min. 5. Sociel Security Number 7. Age (In yrs. last birthdey) 8. Dete of Birth (Month, Dey, Year) Birthplece (State or Foreign Country) **Funeral** 1 M 2 1 F 215-40-9088 Yrs. Director 25 1916 DENMARK Usual Residence of Decedent with the Meryland 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits items 23s or 28s-f show event, the Medical Examiner must be notified at 1 Yes 2 No PARKVILLE Director BALTIMORE MD. 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 8731 LITTLE WOOD RD. 21234 permit. Pages 1 and 2 should be filled within 72 hours efter death 1 Department of Health and Mental Hygiene. Important: If Item 27 Ie marked other than "nature", or itema 23 any injury or other treumatic event, the Medical Examiner must Funeral U.S.A. 14. Rece - American Indien, Bleck, White, etc. 12. Wes Decedant Evar In U.S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 Never Merried 2 Married 1 ☐ Yas 2 ☑ No If Yes, Give Yaer or Detes: Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No þ Specify. 3 ₩idowed 4 Divorced WHITE Completed 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) Coilege (1-4or 5+) 12 YR5 2 yrs HOUSEWIFE HOME 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be 2 SOPHIA ANDERS CHRISTENSEN 19a. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) JOHN BEL-AIR BECKER CARRS 1106 21014 20b. Pleca of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition Dete 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Ramovei from State 12-16 REENMOUNT CREMATOR 4 ☐ Donetion 5 ☐ Other (Specify) BALTIMORE 21. Signeture of Funerel Sarvice Licens 22. Neme and Addrass of Facility CHAPEL OF MEMORIES EVANS 8800 HARFURD RD. Part. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each lina. Approximate Interval Between Onset and Death **Physician** /Medical immediate Cause (Finel disease or condition resulting in deeth) Examiner e to (or es e consequence of): Examiner To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the ettending physician and bunial-transit Sequentielly list conditions, if any, leeding to immediate cause. Entar Underlying Ceuse (Diseese or injury that initiated events resulting in death) Last Due to (or es a consequence of): Box 68760. ettending physician Physician/Medical Due to (or as a consequenca of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. Division of Vital Records, P.O. 23b. Did tobacco use contribute to the cause of death? signed by t 1 Yes 2 No 3 Probably 4 Unknown Aression Completed by 24e. Wes en autopsy pertormed? 24b. Were eutopsy findings available prior to completion of cause of deeth? 25 No 1 ☐ Yes 2 ☐ No Be 25. Wes case refarred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 1 Yes 2 WNo 1 ☐ inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28a. Dete of injury (Month, Dey Year) 27. Menner of Deeth 28c. Injury et Work? 28b. Time of Certification: 28d. Dascribe how injury occurred 5 Pending Investigation 1 Netural 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 Could not be determined 3 Suicide Placa of Injury - At homa, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide edicai 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end piece, and due to the cause(s) and menner es steted.

2 Madical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, date end piece, and due to the cause(s) end menner stated. 29e. Certifier (Check only one) 29b. Signature end title of certifier 29d. Dete signed (Month, Day, Year) 29c. Licensa number 30. Neme end eddress of person who completed cause of deeth (Item 23a) (Type, Print) TAYLOR AVE KHIN 1006 TUN 31. Dete filed (Month, Dey, Year) 32 Registrer's Signature State DEC1 91995 Registrar

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 95

						Cei	rtificate o	f Death		Reg. No.				
Ε.	N1-1		1. Decedent's Neme (First, Middle, Las	t)					2. Date of E		Voor	3. Time of Deeth		
	hysici /Medio		KARAL BI	LLS					DEC.	14, 1	995	0735 A		
	Examir		4e. Facility Neme (If not Institution, give GOOD SAMARITAN			R.		BALTI	The state of the s					
Dir	ineral rector		5. Social Security Number 6. Sec. 219 – 38 – 2629 11 Usual Residence of Decedent	ex □ M 2) X F	7. Age (In yrs. lest	birthdey) Yrs.	If Under 1 Yea Months Days		Min. 8. Date of E (Month, I AUG	Sirth Dey, Year) 10,1942	9. Birthp Cour	plece (Stete or Foreign http) RYLAND		
yland	MOM		10a. Stete 10b. County		10c. City, T	own or Lo	cation					Od. Inside City Limits		
Mer		tor	MD. BALTI	MORE	R	RRY	14966					1 ☐ Yes 2 Bond		
th the	or 28	Director	10e. Street end Number				10f. Zip Code			10g. Citizen of	What Cour	ntry?		
w Ch	23a		1708 FREDKER	T AL	VE.		2	1236		U	5. A.			
0	al', or items 23a or 28a-f show Examiner must be notified at	by Funeral	11. Maritel Stetus 1 □ Never Married 2 □ Merried 3 ጮWidowed 4 □ Divorced	12. Wes Dece Armed Fo 1 Tes If Yes, Giv Yeer or D	2. No		Wes Decedent of If Yes, specify Cu 1 ☐ Yes 2 ☑ N	iben, Mexican, F	No- 14. Rec Ble Specif	ck, White,				
2 hor	natural', sdical Ess	ted	15. Decedent's Ed	ucetion	1	8a. Deced	dant's Usuel Occ	upation	fadda	16b. Kind of B	usinass/In	dustry		
thin 7	A 450	Completed	(Specify only highest grad Elementery/Secondary (0-12)	College (1	I-4or 5+)	life.	kind of work don DO NOT use ratii	e during most o red)	t working	1				
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should be	marked matic e	70		ZIEK				EDZ	77/ /1/	CORD				
d 2 sho	모른		19a. Informent's Neme/Reletionship (7			19b. Mailir	- Control		or Rural Route Num	nber, City or Town	Steta, Zip	Code) 21236		
199	Item 27 other t		20e. Method of Disposition	BILL		e of Dispo	osition (Neme of	KERT	Dete	20c. Location	City or To	np,		
0 6	- 2		1 Burlal 2 ☐ Cremetion 3 ☐		State cem	etery, crer	metory or other p	,	12/18					
it. P	ndru nlun		4 □ Donetion 5 □ Other (Specify 21. Signature of Funeral Sequence				Kupao				WILL	E		
Departm	Important: I any injury o once.		John Em	le	2	5	Ph 4	CHAPEL	OF MET	21234	/			
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t the	ed by the detached	Phy	Pert II. Other eignificant conditions co			ig in the u	nderlying cause (given in Pert I.		d tobacco uee co □ Yes 2□ No	3 Pro	the cause of death bably 4 XUnknow		
requires	been sign	Completed by								es en autopsy rformed?	ev	are eutopsy findings elleble prior to mpletion of cause daeth?		
The law	ata has page 2	дшс							10	Yes 2 No				
			25. Wes cese refarrad to medical					26 Place o	f Daeth (Check only		11,	Yes 2 No		
	is certific director,	To Be	axaminar?	Hospitai:	npatient XXER	/Outpetier	nt 3 DOA	Wher:			ar (Specif	(v)		
ding.	After the funeral										Residence 6 Other (Specify)			
of the	Il Director: ed in by the	Certification:	3 Suicide 6 Could not be datarminad	28e. Plece buildir	of Injury - At home ng, etc. (Specify)	, ferm, str	eet, factory, offic	в		(Street end Numi own, Stete)	ber or Run	al Route Number,		
Hospital A hours e	completaly filled in	edical (29a. Certifiar (Check only one)	sician: To the iner: On the be	tent of my knowled this of examinetion her stated.	dge, daath end/or inv	n occurred et the vastigation, in my	time, dete end propinion, deeth	plece, end due to the occurred et the time	a causa(s) and me, dete end piece,	annar as s and due to	tated. the ceuse(s)		
To the within 2	Comp	Me	29b. Signature and title of certifier	Solle	A			nse number C.M.E		29d. Dete signe DECEM		Dey, Year) , 1995		
	2		30. Name end eddrass of person whole MARIO F. GOLUG J 31. Dete filed (Month Ref. Mee/IO **)	R MD		enn		, Balt	imore,	Marylan	d 21	201		

Registrar

TO THE HOSPITAL, OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-tro	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: Il Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
10	10	De file	MP

ITEM7, g-731, 1-29-96, perf.h., dk

FOR
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
REGISTRAR

CERTIFICATE OF DEATH
REG. NO.

	REGISTRAN		- OL		VAIL	<u> </u>	DEAL		PIE	G. NO.			
	1. OECEDENT'S NAME (First, Middle, Last)								2. DATE OF D	DAY		VEAD	TIME OF DEATH
	Helen		Biedr		i				Decemb			.995 4	1;40 A M
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. lest		MONTHS E	YEAR DAYS	IF UNDER	24 HRS.	7. DATE OF BI (Month, Day,	191 (Har)	5	B. BIRTHPL: Country)	ACE (State or Foreign
	212 16 9834	1 M 2 XF	80	YRS.	months t		nouna		May 2	, 192	25.	Mar	ryland
	9e. FACILITY NAME (If not institution, give st				9b. CITY, TO			ON OF DEA	TH	1		TY OF DEAT	
DIRECTOR		xton			Towson							CIMOI	
5	RESIDENCE OF DECEDENT 10a, STATE 10b, COUNTY	,		10+ CIT	r. TOWN OR	1.0047	1011					1.0	d, INSIDE CITY
<u>E</u>		ltimore		100. 011	•								LIMITS?
	10e. STREET AND NUMBER	Baltimore Parkville											T COUNTRY?
RA	8328 Edgedale Rd.	1011 211 0002											
FUNERAL		1. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Spe									.S.A.		
5		Never Merried 2 V Merried FORCES? 1 YES 2 NO If yes, specify Cubert, Mexican, Puerto Rican, etc.)								ecity tee o	r No-		American Indian, fhite, etc.
BY	3 ☐ Wildowed 4 ☐ Divorced IF YES, GIVE WAR OR DATES 1 ☐ YES 2 [X NO Specify: Specify:								Specify:	White			
	16. DECEDENT'S EDUCATION 160, DECEDENT'S USUAL OCCUPATION 16b, KIND OF BUSINESS/INDUSTRY							JSTRY	MILTOC				
	(Specify only highest grade completed) (Give kind of work done during most of working life. Do NOT use retired.) Elementary/Secondery (0-12) College (1-4 or 5+)												
립	8 vr's			Homen	aker				0	wn H	ome		10.0
COMPLETED	17. FATHER'S NAME (First, Middle, Last)						18. MOTH	HER'S NAM	E (First, Middle				
BE (19+. INFORMANT'S NAME (Type/Print)				ADDRESS (S	Street o			oute Number, Ci				
2	Mr. Stanley J. Bi	iedrzycki		Same	as #	10							
	20e. METHOD OF DISPOSITION 1 X Burlel 2 Cremetion 3 Reme		20b. PLACE A	NDDATE	OF DISPOSITI	ON /Na	me of		DATE	20c. LOCA	ATION C	City or Town	, State
	4 Donetion 5 Other (Specify)	over from State	cemetery, crer	Par	kwood	Ce	em.	12/2	0/95	Bal	timo	re.MD	
	21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEE						SS OF FACI	ILITY Ba	1time	ore.	MD 21	214
	+ faul L. Hart	Tento che			Le	ona	rd J	l. Ru	ck,Inc				
	23. PART I. Enter the diseases, or cannot shock, or haert failure.	complications the	it ceused the de	ath. Do n									Approximata
	shock, or haert failure. iMMEDIATE CAUSE (Final	List only one cer	use on each ilna.	1		Λ			1				intarval Between Onset and Death
	disease or condition	Mo	Tous Coll			1/1	ma	((and	DA			
	resulting in death)	DUE TO	OR AS A CONSEC	UENCE OF	F):	V	010	7 6	011				
~		_ (7.11.	F									
<u> </u>	Sequentially ilst conditions, if any, leading to immediate	DUE TO	TOR AS A CONSEC	UENCE O	F):								
CERTIFICATION	cause. Enter UNDERLYING CAUSE (Disease or injury	С.											
Ē	that initiated eventa	DUE TO	(OR AS A CONSEC	UENCE OF	F):								
E	reaulting in death) LAST	d											
	PART ii. Other significent condition	s contributing to	death but not re	esultina	In the unde	erivino	Ceuse o	niven in P	Part 1. 24a	WAS AN A	UTOPSY	24b W	ERE AUTOPSY FINDINGS
EDICAL			300111 001 1101 11	o da ming		on you	, 00000	g. v O (1 1 1 1		PERFORM	IED?	A	MILABLE PRIOR TO OMPLETION OF CAUSE
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A	DID TOBACCO USE CONTI	KIBUTE TO CA			TH (Check on		UNC	EKIAIN					
PHYSICIAN:	EXAMINER?	HOSPITAL:							Other (Spe				
Ϋ́	1 YES 200 NO	28e. DATE Of	ER/Outpetient 3	28b. TIM			o 5 □ Re				U		
	1 Netural 5 Pending	(Month, I			URY	WO	RK?	.	28d. DESCRIB	E HOW IN.	JUNY OCC	UHED	
В	2 Accident Investigation	28a PLACE	OF INJURY — At ho	ma form	m l			-	204 0047104	M (Or	4.666	0 0	
8	3 Suicide 8 Could not be 4 Homicide determined	building	atc. (Specify)	me, mm,	erreet, rector	y, orner			281. LOCATION	vn, State)	a Number	or Hural Hou	na Number,
COMPLETED	29e, CERTIFIER												
릴	(Check only												
ŏ	2 MEDICAL EXAMINE	R: On the basis of a	exemination end/or i	nvestigatio	n, In my opi	nion, d	eath occur	red at the t	ime, date end	place, end	due to the	e ceuse(s) e	nd menner es stated,
ш	296. SIGNATURE AND TITLE OF CERTIFIER	1	Man				20c. LICE	ENSE NUMI	BER		29d. DATE	SIGNED M	loosh, Day, Year)
0 8	\sim	hlo'	1111	/.			104	7+	36		D / 2	4-1	7-4)
5	30. NAME AND ADDRESS OF PERSON NA	COMPLETED CAL	E OF OSTITUTES	1 27) (Type,	Print)		0 1		1			1	1
	Hyman	HKK	HI)	10	01	(r	1AY	-les		2	tre	199
	31. DATE FILED (MODIN, Day, Year)	REGISTR	AR IGNATURE										
	1 0 CO T 0 1333 30		-										

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BANK S.

22. REGISTRAR'S SIGNATURE

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH OROTHEAC. BELL DECEMBER 1995 11:20 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year) 8. BIRTHPLACE (State or Foreign 1915 New York 070-05-2152 1 M 2 Y F 80 Aug. 18, permit. Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH NORTH PRESIDENCE OF DE ARUNDEL DIRECTOR ARUN Del HOSPITAL ANNE BURNIC 10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? Maryland Anne Arundel Pasadena 1 TYES 2 NO 10e. STREET AND NUMBER FUNERAL 10g. CITIZEN OF WHAT COUNTRY? 101. ZIP CODE 7779 Old House Road 21122 page 5 should be detached for use as the burial-transit retained by the hospital or attending physician 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☑ NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, White, etc. Specify: White BALTIMORE, MARYLAND 21215-0020 1 Never Merried 2 Married If yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 YES 2 NO Specify: BY 3 Widowed 4 Divorced COMPLETED 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only hig Elementary/Secondary (0-12) College (1-4 or 5+) Food Broker 12 Secretary 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surneme) 育 Charles Clayton Cook Anna Brunner BE notified 19a. INFORMANT'S NAME (Type/Print) (son) 19b. MAILING ADDRESS (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 2 7779 Old House Road-Pasadena, Maryland Kenneth G. Bell 21122 Page 6 may be 99 20a. METHOD OF DISPOSITION
1 Buriel 2 Cremation 3 Removal from State 20c. LOCATION — City or Town, State 20b. PLACE AND DATE OF DISPOSITION (Name of must funeral director, cemetery, crematory or other piece) 4 X Donation 8 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICENSEE RONald S. Wade, Dil 22. NAME AND ADDRESS OF FACILITY BOARD-655 W. Baltimore St. examiner hours after death. 12/12/96 Rm. B026-Baltimore, Maryland 21201-1559 and completely filled in by the oburtal, cremation, or removal. medical 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, Approximata shock, or heart failure. List only one cause on each line. MMEDIATE CAUSE (Finel **Onset and Death** the disease or condition_ ELASIATIC LUNG CANCER IEN MONTAS event, resulting in death) DIVISION OF VITAL RECORDS, P.O. BOX 68760 DUE TO (OR AS A CONSEQUENCE OF): traumatic CERTIFICATION Sequentially list conditions, OUE TO (OR AS A CONSEQUENCE OF): 2 if sny, leading to immediate cause. Enter UNDERLYING the attending physician Mental Hygiene prior to death certificate be CAUSE (Disease or Injury other DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 0 any injury, PART II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. MEDICAL 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS signed by the AVAILABLE PRIOR TO COMPLETION OF CAUSE 1 YES 2 NO 1 YES 2 NO has been Dept. of h DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) The item the State of **EXAMINER?** HOSPITAL: OTHER: 1 YES 2 NO Inpetient 2 - ER/Outpetient 3 - DOA ATTENDING PHYSICIAN: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 6 27. MANNER OF DEATH this c 28e. DATE OF INJURY 28d. DESCRIBE HOW INJURY OCCURED 28b. TIME OF INJURY 28c. INJURY AT WORK? marked, 1 Natural 5 Pending 1 YES 2 NO BY After Investigation 2 Accident 28s. PLACE OF INJURY — At home, farm, streat, factory, office building, atc. (Specify) 60 3 Suicide 281. LOCATION (Street end Number or Rural Route Number, City or Town, State) 6 Could not be determined COMPLETED DIRECTOR: 4 Homicide 28 DR 29a. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner ee stated. TO THE HOSPITAL D
TO THE FUNERAL D
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IMPORTANT: It is MEDICAL EXAMINER: On the basis of exemination end/or investigation, in my opinion, death occured at the Hime, date end place, end due to the ceuse(a) and manner se stated. 290, SIGHTORE AND TITLE OF CENTIFIER 29c. LICENSE NUMBER BE 29d, DATE SIGNED (Month, Day, Year) D46029 DECEMBER HOUSE MEDIAL STAFF 1995 2 RESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) K. GADUBA, MD NORTH ARUNDER HOSPITAL 301 HOSPITAL DRIVE

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1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

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II.	4 Donation 5 Other			0	ak L	Awn	Cem	ete	ery	12/	16/95	Ва	alit	more	e MD.
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22. NAME AND ADDRESS OF FACILITY Cremation Society of Md., Inc. 299 Frederick Rd. Balto., MD 212. 29. PART I. Enter the diseases, or complications that caused the death. Do not enter the mods of dying, such as cardiac or respiratory arrest, interval Bs onset saline. IMMEDIATE CAUSE (Final diseases or condition resulting in death) Sequentisity list conditions, if any, isading to immediate cause. Enter UNDERLYING CAUSE (Disease or Influry that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): CAUSE (Disease or Influry that initiated events resulting in death) LAST PART IX (Other significant conditions, portributing to death but not resulting in the underlying cause given in Part I. DUE TO (OR AS A CONSEQUENCE OF): ALL CAULAGE DUE TO (OR	 	20a. METHOD OF DISPOSITION 20b. PLACE	AND DATE OF DISPOSITION IN	ame of DA	ATE 20c. LOCATION —	City or Town, Stata			
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2 Accident investigation investigation 2 NO NO		EXAMINER? t YES 2 NO HOSPITAL: 1 Impellant 2 ER/Outpetient	3 DOA OTHER:	me 5 Residence 8 01		CHOEN			
29s. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year)	ED BY	Natural 5 Pending Pending	M 1	ORK? YES 2 NO 281. LC	DCATION (Street and Number				
296. SIGNATUBE AND TITLE OF CERTIFIER 296. LICENSE NUMBER 296. Date SIGNED (Month, Day, Year)	IPLET	29a. CERTIFIER (Check only cools) CERTIFYINO PHYSICIAN: To the best of my knowledge, of the cools of the coo							
36 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Ann. Provi	띪	Youranddar)		29c. LICENSE NUMBER	_	TE SIGNED (Month, Day, Year)			
38" NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)	-	ARMINODO SARDI - 900 CA	A	St Agais	Horps. 2	1229 (BALTION:			



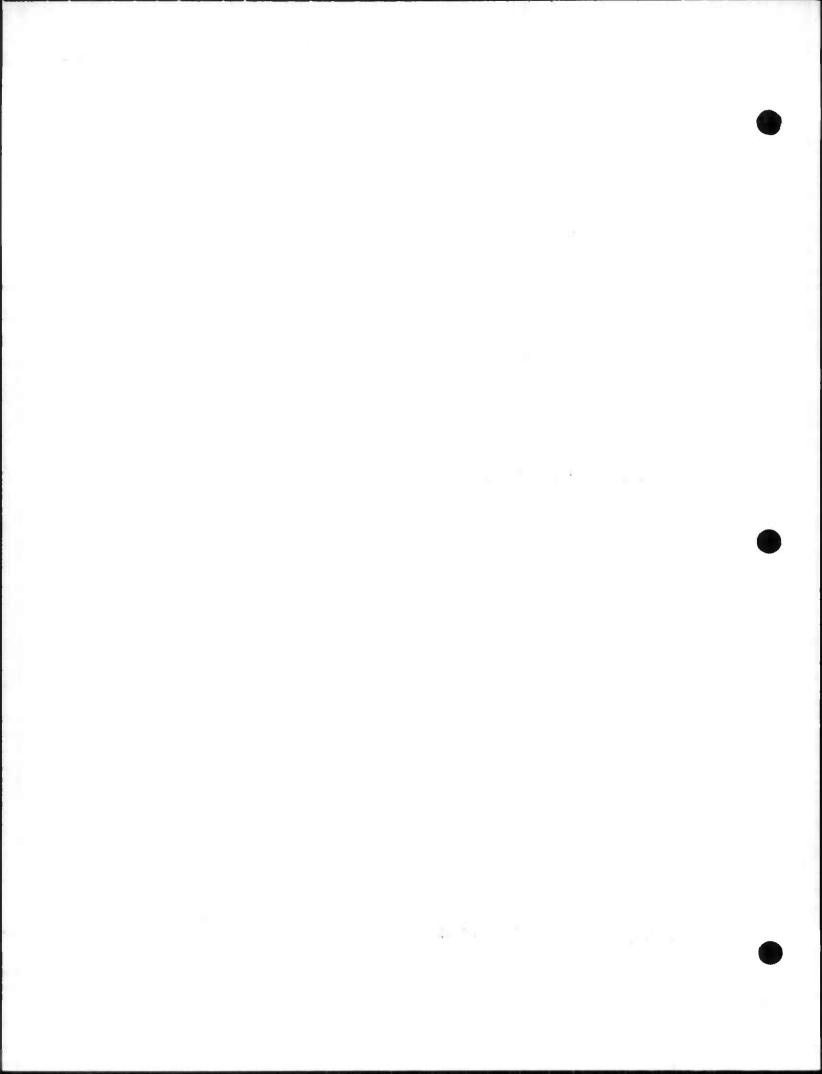
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BALTIMORE, MARYLAND 21215-0020	ifter death. Page 6 may be retained by the hospital or attending physician.	the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should
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DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hosp	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detache		IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	
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뿔	뿚	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	POR	
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	1 - FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPAR	RTMENT OF H	EALTH AND M	MENTAL HYGIEN			
	1. DECEDENT'S NAME (First, Middle, Last)	2 1				2. DATE OF DEATH		3. TIME OF DEATH	
	Robert Lee	Beal				DEC 17	1995 1	2:30 P M	
	4. SOCIAL SECURITY NUMBER 217-01-8550	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)	8. BIFT	THPLACE (State or Foreign			
			8() YRS.	- Carlo	HOOMS MAIN	FEB 26, 19	ryland		
œ	So. FACILITY NAME (If not Institution, give s Lorien Nursing (OR LOCATION OF DEA	ATH	9c. COUNTY OF		
DIRECTOR	RESIDENCE OF DECEDENT	enter		Colum	ola		Howard		
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3AL	10e. STREET AND NUMBER	Dood		101	. ZIP CODE		College and College	WHAT COUNTRY?	
FUNERAL	59 Garden Ridge				21228		US	A	
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B	3 Widowed 4 Divorced	IF YES, GIVE WAR OR D.	ATES	1 TYES	2 NO Specify:		Spe	White	
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	Elementary/Secondary (0-12)	College (1-4 or 5+)	Ille. Do NOT u	se retired.)	at or working				
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2	Marie D. Beal					tonsville,		28	
	26a. METHOD OF DISPOSITION 1 General Surfey 2 Commention 3 General Rem	200	PLACE AND DATE	OF DISPOSITION /Na	me of	DATE 20c LO	CATION — City or 1		
	4 Donation 5 Other (Specify)	Me	tro Cren	atory, 1	nc. 12/1	8/95 Ba	ltimore,	MD	
	21. SIGNATURE OF FUNERAL SERVIOS LI	Ma Mel	-	Cremat	I ADORESS OF FACE	ety of Mar			
	George E. Mac	cNabb		299 Fr	ederick 1	Rd. Baltin	ore. MD	21228	
	23. PART I. Enter the diseeses, or shock, or heart failure.	complications that caused List only one cause on e	the death. Do i	not sitter tha mo	de of dying, such	as cardiac or respi	ratory srrest,	Approximats interval Between	
	IMMEDIATE CAUSE (Final disease or condition	2111		,	, ,			Onset and Death	
	disease or condition resulting in death) s. Prohable Cardiac arrive thmia DUE TO (OR AS A CONSEQUENCE OF):								
_									
CERTIFICATION	Sequentially list conditions, If any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF)								
2	cause. Enter UNDERLYING CAUSE (Disesse or Injury	a Aartic	Valve	Replaces	1				
	that initiated events resulting in death) LAST	DUE TO OR AS A	CONSEQUENCE O	F): /					
E E		d. Recent	Coleci	amy					
	PART II. Other significant condition	is contributing to death b	ut not resulting	in the enderlying	causa givan in P	Part I. 24s. WAS AN	AUTOPSY 24	b. WERE AUTOPSY FINDINGS	
MEDICAL	-					1 YES 2	NO	COMPLETION OF CAUSE OF DEATH?	
ME								1 TES 2 NO	
PHYSICIAN:	DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL	P			UNCERTAIN				
Sign	EXAMINER?	HOSPITAL:	28. PLACE OF DEA	OTHER:	Krestevi III				
H	27. MANNER OF DEATH	28a. DATE OF INJURY	28b. TIM	E OF 28c, INJ	5 Residence 8	28d. DESCRIBE HOW IN	NJURY OCCURED		
	1 Natural 5 Pending	(Month, Day, Year)	INJ		RK? ES 2 NO				
3 Suicide 6 Could not be 28e. PLACE OF INJURY — At home, ferm, street, factory, office 28i. LOCATION (Street and								Route Number,	
=	4 Homicide determined					City or Town, State)			
CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) end menner ee stated. Chack only Chac									
Š.	MEDICAL EXAMINE	On the tasie of examination	n end/or investigation	n, in my opinion, de	eath occured at the ti	me, date end place, and	d due to the cause	(e) and menner se stated.	
BE	396. SIGNATURE AND THOSE OF CERTIFIES	· N			29c. LICENSE NUME	BER	29d. DATE SIONE	D (Month, Day, Year)	
ē	30. NAME AND ADDRESS OF PERSON WH		ATLI ATPACAT	0.1.0	BD 4610	0475	Dec	17,1995	
	That's DA.	110 55 1 11	D. L N.	LD.		1 / 1	110	~ ~ .	
	31. DATE FILED (Month) On Your	32 DEGISTRAR'S CH	ATURA	W rank	way C	olumbic	MI) 2	2016	
	31 DEC 1 9 1995	DE CONTRACTOR			Į.				





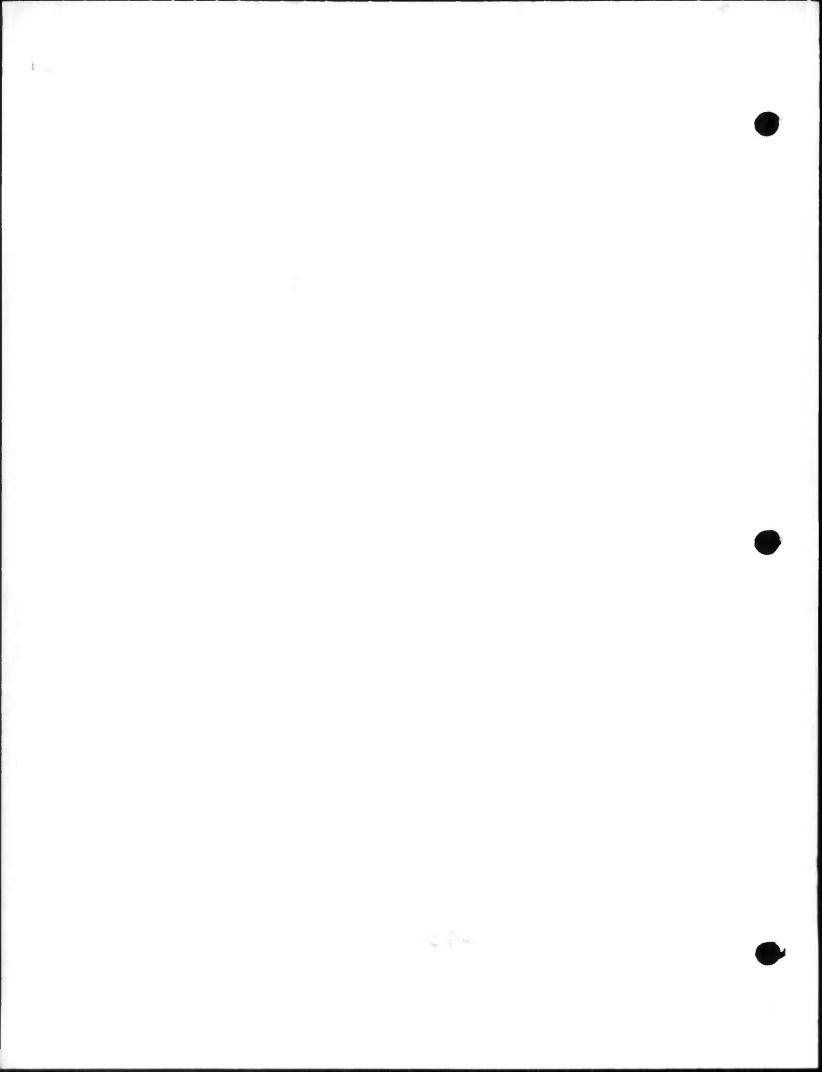
TO THE HOSPIDAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within. In how the fine the factor, page 5 may be retained by the hospital or attending physician.

TO THE RUNERAL DIRECTIOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If them 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	1 - STATE REGISTRAR	STATE OF MARY	LAND / DEPAR CERTIF	TMENT OF	HEALTH AND	MENTA	L HYGIEN	E		
	1. DECEDENT'S NAME (First, Middle, Last) Marie Pauline Brown 2. Date of Death DEC 15 DAY 1995 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In vir. line) birthday) IS INDER 3 VEAR IS INDER 3									
	214-38-1416	1 □ M 2 🂢 F	86 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE	7. DATE OF BIRTH AUG 31, 1909			and
TOR	9a. FACILITY NAME (If not institution, give Ginger Cove Hea. RESIDENCE OF DECEMENT			Annapo	or Location of	DEATH		Anne Arundel		
DIRECTOR	Maryland Anno	e Arundel	10c. CIT	Y, TOWN OR LOCA	Annapolis					Dd. INSIDE CITY LIMITS? YES 2 NO
FUNERAL	4000 River Cres		11	M. ZIP CODE 214()1			N OF WH	AT COUNTRY?	
ВУ	11. MARITAL STATUS 1 Never Married 2 Married 3 Nidowed 4 Divorced	12. WAS DECEDENT EVE FORCES? 1 YE IF YES, OIVE WAR OF	S X NO	If yes, s	CENDENT OF NISP pecify Cuban, Mexi 8 2 X NO Spec	can, Puerto	N? (Specify Yea Rican, etc.)	or No-	Black, \	American Indian, White, etc.
COMPLETED	16. DECEDENT'S E (Specify only highest gri Elementary/Secondary (0-12)	College (1-4 or 5+)	(Give kind of a	EDENT'S USUAL OCCUPATION Is land of work done during most of working to NOT use related.) The property of the						
BE CON		Edward Menke			18. MOTNER'S N	Kath	Middle, Malden nerine	sumame) Wacke:	r	
2	1990. INFORMANT'S NAME (Type/Print) Eloise E. Weimer		3801 H	Baker Sc	and Number or Rura hoolhous	se Rd	. Linel	oro,	MD 2	
	20s. METNOD OF DISPOSITION 1									D
	21. SIGNATURE OF JUNERAL SERVICE George E. Ma			299 F	tion Soc rederich	Rd.	Baltin	nore,	MD 2	nc. 21228
	23. PART I. Enter the diseases, or complications that caused the death. Do not anter the mode of dying, such as cardiec or respiratory arrest, abock, or heart failure. List only one cause on each line. Approximate Interval Between									Interval Between Onset and Death
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST									
4	PERFORMED? AMAILA									ERE AUTOPSY FINDINGS MILABLE PRIOR TO DMPLETION OF CAUSE
N: MEDIC	DID TOBACCO USE CON	ITRIBUTE TO CAUSE	OF DEATH YE	s 🗆 NO [UNCERTA		1 TES 2	₽ NO		F DEATH?
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 Yes 2 No	HOSPITAL: 1 Inpetiant 2 ER/O	26. PLACE OF DEAT	OTHER:	ne 5 🗆 Residence	6 Othe	er (Specify)			
BY PH	27. MANNER OF DEATH 1 Netural 6 Pending 2 Accident Investigation) INJ	M 1	JURY AT DRK? YES 2 NO	28d. DE	SCRIBE NOW IP	JURY OCCUI	PED	
	3 Suictde 8 Could not b 4 Homicide detarmined	28s. PLACE OF INJU building, atc. (S	RY — At home, term, a pec/fy)	draet, tectory, offi			ATION (Street a or Town, State)	nd Number or	Aurel Rou	e Number,
COMPLETED		/SICIAN: To the best of my kn NER: On the basis of axamine								nd manner sa stated.
TO BE	296. SIGNATURE AND TITLE OF CERTIF	WHO COMPLETED CAUSE OF	DEATH STEM 27) (Tone	Print	29c. LICENSE NO	UMBER				onth, Day, Year)
	31. DATE FILED-(Month, Day, John)	84 2603 1 32 REGISTRAR'S SI	MSD: PI		# 100	Ace	nepox	Ze p	ed	21401
	1 0 1333	Juli d'hudeard	artell							DUME to Ben (MO





DIVISION OF VITAL RECORDS, P.O. BOX 68760 98

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH ERKOWITZ LUCY 9 get DEC 12:05/ 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) BIRTHPLACE COURSES IA IF UNDER 1 YEAR | IF UNDER 24 HRS. 7. DATE OF BIRTH THPLACE (State or Foreign APR. 157, 1904 010-07-1258 91 DAYS HOURS 1 M 2 X F Pages 1, 2, 3 should 9s. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR BALTIMORE N/A LEVINDALE. RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY
LIMITS?
1 YES 2 NO MARYLAND N/A BALTIMORE permit. 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10s. CITIZEN OF WHAT COUNTRY? 6101 WIRT AVE. 21215 USA **burial-transit** retained by the hospital or attending physician. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 11 MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-If yes, specify Cuban, Mexican, Puerio Rican, etc.) 14. RACE — American Indian, Black, White, alc. FORCES? 1 YES 2 IF YES, GIVE WAR OR DATES 1 Never Married 2 Married 1 TYES 2 THO BY Specify: Specify: WHITE 3 X Widowed 4 Divorced and completely filled in by the funeral director, page 5 should be detached for use as the burial, cremation, or removal. 0 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade COMPLET ntary/Secondary (0-12) College (1-4 or 5+) HOUSEWIFE 11 OWN HOME 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) FREEDMAN **DOCTORMAN** notified at KALMAN ATDEL BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 SIDNEY BERKOWITZ 6101 WIRT AVE. BALTIMORE, MD 21215 Раде 6 тау be pe 20s. METHOD OF DISPOSITION
1 Burlet 2 Cremation 3 KRamoval from State 20c. LOCATION -- City or Town, State 20b. PLACE AND DATE OF DISPOSITION (Name of OATE must COMPRIDE ON OF THE PYNN 12/17/95 LYNN, MA 4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICENSEE examiner SOL LEVINSON & BROS., INC. 6010 REISTERTOWN RD. 21215 Uno BALTO., MD medical 23. PART-I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardisc or respiratory arrest, Approximate , or heart fallure. List only one cause on each line. Interval Between IMMEDIATE CAUSE (Final **Onset and Death** the disease or condition nelor 2 mo event, reaulting in death) DUE TO (OR AS A CONSEQUENCE OF) d other traumatic CERTIFICATION MU Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): the attending physician at Mental Hygiene prior to If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disesse or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 0 PART II. Other algorificant conditions contributing to death but not resulting in the undarlying cause given in Part I. MEDICAL 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO Health and N Emeshelizettu shows any 1 TES 2 NO COMPLETION OF CAUSE OF DEATH? 1 | YES 2 | NO peen to DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN has be Dept. PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) Item ATTENDING PHYSICIAN: The certificate h HOSPITAL:
1/A Inpetient 2 ER/Outpetient 3 DOA 1 YES 2 NO OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify) 6 27. MANNER OF DEATH 28a. DATE OF INJURY . this c marked, 28b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 Natural INJURY 1 YES 2 NO DIRECTOR: After the hours after death v BY Investigation 2 Accident 28s. PLACE OF INJURY — Al home, farm, streel, factory, office 60 3 Sulcide 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 8 Could not be 4 Homicide 28 29a. CERTIFIER

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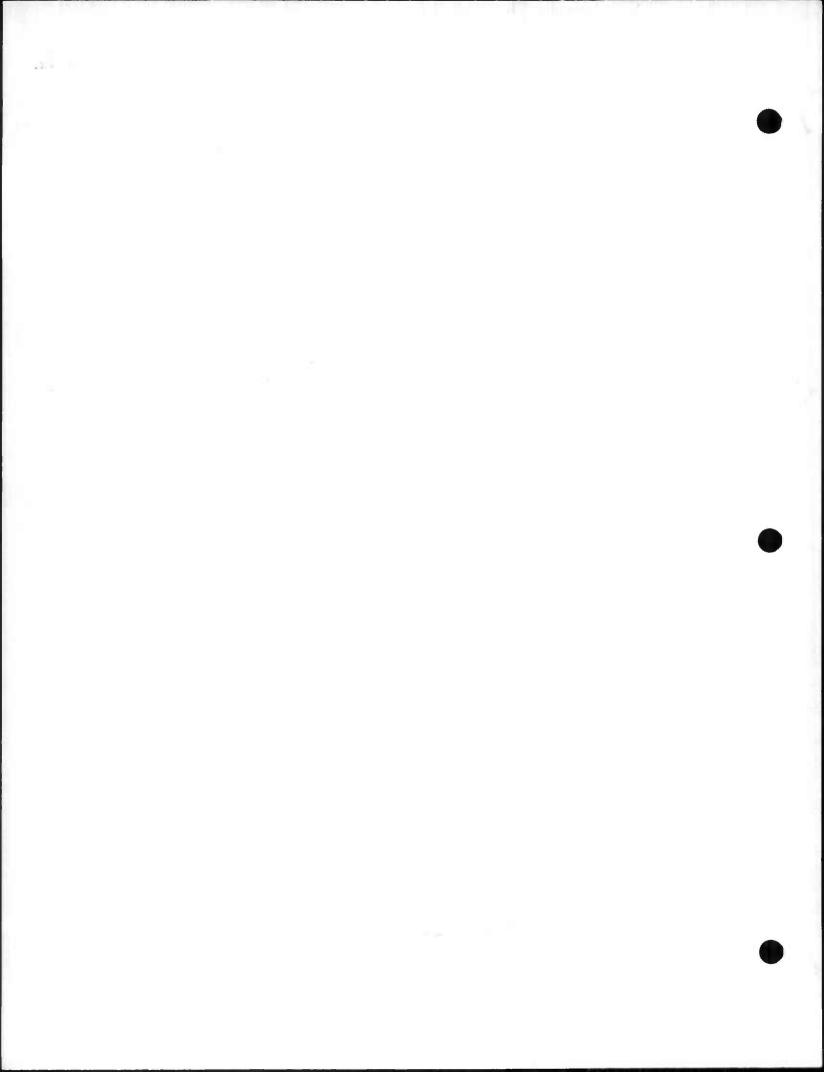
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(C TO THE HOSPITAL TO THE FUNERAL C be filed within 72 h 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29d. DATE SIGNEO (Month, Day, Year) BE physican D ule 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

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		FOR STATE REGISTRAR	STATE OF MA					ALTH AND I	MENTAL HYGIENI REG. NO.	E		
		DECEDENT'S NAME (First, Middle, Last) GERTRUDE			RGSTE				2. DATE OF DEATH MONTH DEC. 16	1995	3. TIME OF DEATH 12:37 A	
<i>'</i>	2	4. SOCIAL SECURITY NUMBER	5. SEX 6.	AGE (In yrs. I		IF UNDER		IF UNDER 24 HRS.	7. DATE OF BIRTH	6. BIE	THPLACE (State or Foreign	
P		166-30-3314	1 □ M 2 🂢 F	85	YRS.	MONTHS		HOURS MIN.	MAY 25,19	10	RÚSSIA	
3 should	œ	98. FACILITY NAME (If not institution, give street and number) 99. CITY, TOWN OR LOCATION OF DEATH 90. COUNTY OF DEATH 91. FACILITY NAME (If not institution, give street and number) 90. COUNTY OF DEATH 91. CITY, TOWN OR LOCATION OF DEATH 91. CITY, TOWN OR LOCATION OF DEATH 92. COUNTY OF DEATH										
ci	СТОВ	RESIDENCE OF DECEDENT		NG na					عارات	DALI	INORE	
permit. Pages 1,	DIRE	MARYLAND 10b. COUNT	ALTIMORE		10c. CIT	BRO	OKLA	NOVILLE			10d. INSIDE CITY LIMITS? 1 X YES 2 70	
	A.	10e. STREET AND NUMBER					101. 2	ZIP CODE		10g. CITIZEN O	F WHAT COUNTRY?	
physician. burial-transit	NER	515 BRIGHTFIELD				1		21022		USA		
ding physici the burial-	BY FUN	1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT E FORCES? 1 IF YES, GIVE WAR	YES 2	NO	11	yes, spec		NIC ORIGIN? (Specify Yea on, Puerto Rican, etc.) y:	BI	ACE — American Indian, ack, White, etc. WHITE	
r attend use as	E	15. DECEDENT'S EDU (Specify only highest grad	Give kind of	work done d			16b. KIND OF BUS	INESS/INDUSTRY				
spital o	PLET	Elementary/Secondary (0-12)	College (1-4 or 5+)	"		se renea.) 1EMAKI	ER		OWN	HOME		
the hospit detached once.	COMPL	17. FATNER'S NAME (First, Middle, Last)							ME (First, Middle, Maiden			
should be	BE	MORRIS 190. INFORMANT'S NAME (Type/Print)		UNATI			100	ROSE	<u> </u>	MAZC	R	
e 5 should notified	5	MRS. ROSLYN STO	LER		116	SWAN			Route Number, City or Town		908	
ector, page must be		20a. METNOD OF DISPOSITION 1X Burlal 2 Cremation 3 Ran	noval from Stata		E AND DATE			AMUNO)	DATE 20c. LO 12/17/95	CATION — City or	Town, Stata IORE, MD	
Page 6 ma al director, ner must		4 ☐ Donation 5 ☐ Other (Specify)	DENSEE O	AKLI	INGTO				& BROS.,]		ORE, ND	
ter death. Pag the funeral di wal.		Hoel !	2 Te	117					& BROS., I		MD 21215	
s be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician sician and completely filled in by the funeral director, page 5 should be detached for use as the burial-tran rior to burial, cremation, or removal. traumatic event, the medical examiner must be notified at once.	TION	23. FAIT Lenter the diseases, or ehock, or heert failure. IMMEDIATE CAUSE (Finsi disease or condition resulting in desth) Sequentially liet conditions, if any, leading to immediate	a. A DUE TO (OI	eused the con each line con each line con each line constant as a consta	EOUENCE C	ua PP:			AONIA	ratory arreat,	Approximate interval Between Onsat and Death DAYS(5) DAYS(5)	
th certificate anding phys I Hygiene p or other	CERTIFICATION	cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in deeth) LAST	c	R AS A CONS	EOUENCE C	PF):						
at the death by the atter and Mental y injury, o	CAL C	PART II. Other significent condition			resulting	in the un	derlying	ceuse given in	Pert i. 24s. WAS AN		14b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO	
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that in TO THE FUNERAL DIRECTOR: After this certificate has been signed by be filed writhin 72 hours after death with the State Dept. of Health and IMPORTANT: If Item 28 is marked, or Item 23 shows any in	MEDIC	ATHEROS							1 TYES 2		COMPLETION OF CAUSE OF DEATN?	
has be Dept.	PHYSICIAN:	DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL	RIBUTE TO CAU:		ATH Y	ES 1		UNCERTAI	NO			
AN: The	SICI	EXAMINER?	HOSPITAL:		100	OTHER	٠	5 Realdence	6 Other (Specify)			
G PHYSICI, er this cert ith with the	ву РНУ	27. MANKER OF CENTN 1	ISS. DATE OF SA	MA.	28b. 7II	##A	28c. INJU WO 1 /		28d. DESCRIBE HOW	NJUSTY OCCURED		
ATTENDIN ECTOR: An is after dea in 28 is in	ETED E	3 Suicide 6 Could not be 4 Homicide detarmined	35e. PLACE OF building.		home, farm,	street, facto	ory, offica		261, LOCATION (Street & City or Town, State)	Ind Number for Rus	gl Route Number,	
SPITAL OR VERAL DIRI IIN 72 hour VT: 11 iten	COMPLE	29a. CERTIFIER (Check only one) 2 MEDICAL EXAMIN	1						to the cause(a) and mar		e(a) and manner as stated.	
O THE HOO THE FUN Filed with	H	SIGNATURE AND TITLE OF CONTIFIE	ren	(Jot	IT ut	EVE	LIVS	29c. LICENSE NU	MBER 952	29d. DATE SIGN	16 1995	
4=	5	38. NAME AND ADDRESS OF PERSON W	ZLAIR	OF DEATH (IT	1	3 A	LTI	MORI	E MARY			
		DEC1 9 1995	32. REGISTRAR'S	S SIGNATURE	Ц							

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation. or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

FOR 1 - STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAR		C	:RIIF	ICAIE	· UF	DEAL	П		REG. NO.				
	1. DECEDENT'S NAME (First, Middle, Last)								2. DATE O		Y	YEAR	3. TIME OF DEATH	
	Carolyn K.		BOONE						Dece	mber 1	8,19	95	4:08 P M	
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. las		IF UNDER	1 YEAR DAYS	IF UNDER	24 HRS. MIN.	7. DATE C (Month,	Day, Year)		8. BIRTH Country	PLACE (State or Foreign	
	212 62 6884	56	YRS.		Dec. 17,1939 Tenne					essee				
_	Se. FACILITY NAME (If not institution, give s			9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH						EATH				
5	Franklin Square He	ospital C	enter		Ros	Rossville 21237 Baltimore						re		
DIRECTOR	10s. STATE 10b. COUNTY	·		10c. CIT	Y, TOWN O	R LOCAT	TION						10d, INSIDE CITY	
E	Maryland Balti	more		M-	iddle	Di	vor						LIMITS?	
ادِ	10e. STREET AND NUMBER	iore		F1-	LUCIE	-	ZIP CODE				10g. CITI	6g. CITIZEN OF WHAT COUNTRY?		
FUNERAL	106 Yawmeter Drive	9					2	1220			Г	J.S.A	1	
5	11. MARITAL STATUS	12. WAS DECEDEN	T EVER IN U.S. AR	MED			ENDENT O	F HISPAN		(Specify Yes		14. RACE	- American Indian.	
	Never Married 2 Married	FORCES? 1 IF YES, GIVE W	YES 2 NA	10			ecify Cube		n, Puerto R	ican, atc.)		Specif	, White, atc.	
ВУ	3 Widowed 4 Divorced	<u> </u>					21						White	
COMPLETED	15. DECEDENT'S EDU (Specify only highest grade	CATION completed)	(G	CEDENT'S	work done d	CCUPATIO	ON ost of workin	g	16b.	KIND OF BUS	INESS/IND	USTRY		
الإ	Elementary/Secondary (0-12)	College (1-4 or 5+) //fe.	Do NOT us						_				
M	12			HO	usewi	ite				Own H				
	17. FATHER'S NAME (First, Middle, Last)	G	-							iddle, Meiden	Sumame)			
BE	Jessie James 19a, INFORMANT'S NAME (Type/Print)	Groga					Edi			neeler				
2	a series de la companya de la compan	Two											- J 2220	
	Norman E. Boone,	Jr.	20b. PLACE					S MT	DATE		CATION —		nd 21220	
	1 Burlet 2 Cremation 3 Rem 4 Donation 5 Other (Specify)	oval from State	comptony are	metaniara	ther place!			12/2				,	•	
	21. SIGHAT THE OF PUNETIAL SERVICE LIC		Mr. Ol	rvec	22, 1	Cemetery 12/21/95 Frederick, Maryland 22. NAME AND ADDRESS OF FACILITY								
	▶ □ 12	0	A		Br	ruzd	zinsl	ki F	unera	1 Hom	e P.A	A.		
	Man 12	0			14	107	Easte	ern	Ave E	Baltim	ore,	Mary	land 21221	
	23. PARTA. Enter the diseases, or ahock, or heert fellure.	complications that List only one ceu	t caused the de se on each line	ath. Dor	not enter	tha mo	de of dy	ng, sucl	h as card	iac or reapi	ratory arr	reat,	Approximata Interval Between	
	IMMEDIATE CAUSE (Finel												Onset and Death	
	disease or condition resulting in deeth) a. Hypoxic encephalopathy DUE TO (OR AS A CONSEQUENCE OF):										24 hours			
ON	Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF)									15 years				
CERTIFICATION	If any, leading to immediate								15 years					
임	CAUSE (Disease or Injury that Initiated eventa DUE TO (OR AS A CONSEQUENCE OF):													
E	resulting in deeth) LAST	4												
EDICAL	PERFORMED? AMAILA										WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO			
8										t 🗌 YES 2	NO NO		COMPLETION OF CAUSE OF DEATH?	
M													1 TYES 2 NO	
ä	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO X UNCERTAIN 125. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one)													
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:			OTHER									
ΙΥS	t YES 2 NO	1 ² Inpetient 2 28e. DATE OF			Y			reldence	6 Other					
	1 X Natural 5 Pending	(Month, D.		28b. T/M	JURY	WC	JURY AT ORK? YES 2	140	28d. DEŞ	CRIBE HOW I	NJURY OC	CURED		
B	2 Accident Investigation	28e PLACE O	F INJURY — At ho	me term	etraat fact			NO	201 1 001	TION (Street a	and Marmhan	or Own 1 5	South Atumber	
	3 Suicide 8 Could not be 4 Homicide determined	building,	etc. (Specify)	1110, tatin,	ottowt, rect	ory, orne				or Town, State)	Ind Number	Or norar r	noole reginoes,	
	29e. CERTIFIER													
MP I	(Check only 1 & CERTIFYING PHYS													
COMPLETED	2 MEDICAL EXAMINE		mination and/or	investigatio	on, in my o	pinion, o				end place, en	d due to th	TO COUSE(S) and menner se stated.	
BE	29b. SIGNATURE AND TITLE OF CERTIFIE	R 7 1	2				1	ENSE NUI			29d. DAT	E SIGNED	(Month, Day, Year)	
0	Caralyn	tarrell	, m.	0.			14Z	328	412-	899		12/1	8195	
	30. NAME AND ADDRESS OF PERSON WE					D	D - 7			(a.m1	1 0	1007		
	Dr. Carolyn Garr			n 2d.	uare	Dr.	rat	LIMO	re, N	naryla	na 2.	123/		
	DEC1 91995	AZ. HEGISTRA	R'S SIGNATURE											
		A IN THE PARTY.											DHMH-18 Rev 1/89	

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

REG. NO.

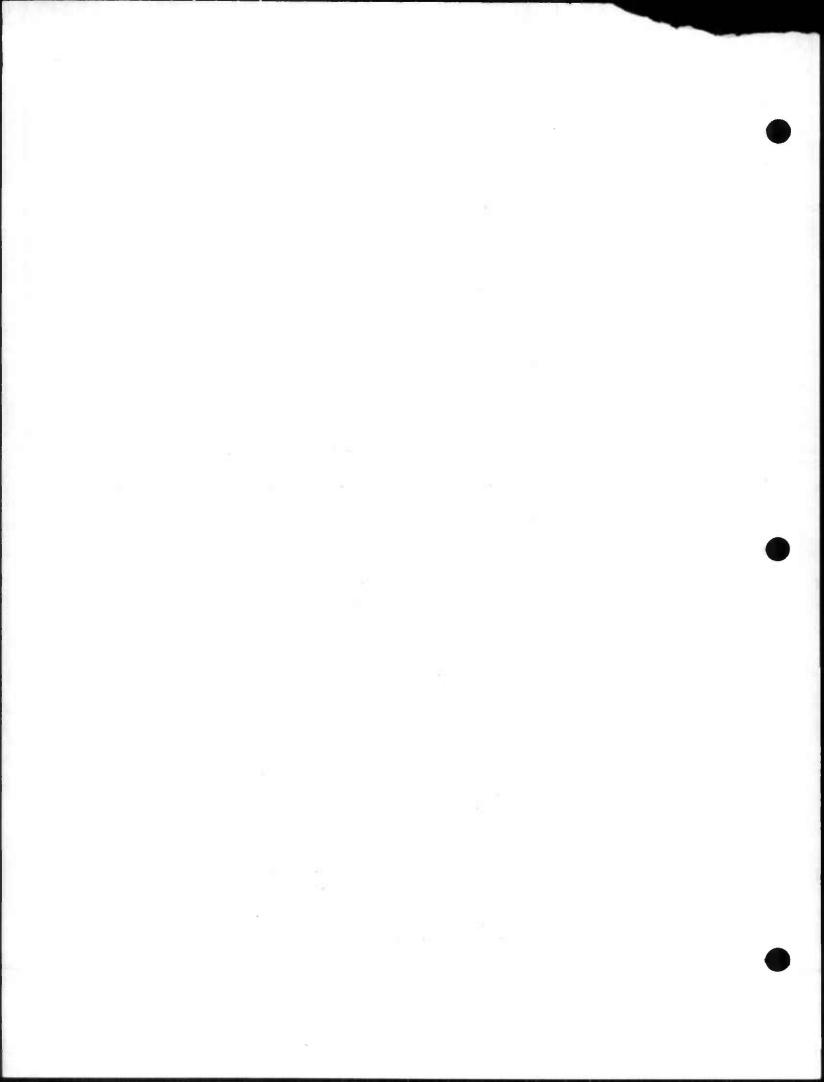
2. DATE OF DEATH

6. AGE (In vrs. last birthday) IF UNDER 1 YEAR | IF UNDER 24 HRS 7. DATE OF BIRTH 8 HOURS 1 M 2 F YRS 9e. FACILITY NAME (If not institution, give street end number) 9b. CITY, TOWN OR LOCATION OF DEATH DIRECTOR RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE hatayette 21216 12. WAS DECEDENT EYER IN U.S. ARMED FORCES? 1 YES 2 NO 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-BALTIMORE, MARYLAND 21215-0020 If yes, specify Cuben, Mexicen, Puerto Rican, etc.)
t ☐ YES 2 ☐ NO Specify: 1 Never Married 2 Married IF YES, GIVE WAR OR DATES BY 3 Widowed 4 Divorced COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade comple 16e. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY (Give kind of work done life. Do NOT use retired.) entary/Secondary (0-12) College (1-4 or 5+) th anade ruch notified at once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Belton 19e. INFORMANT'S NAME (Type/Print) 2 57 pe 20e, METHOD OF DISPOSITION
1 M Buriel 2 Cremetion 3 Removal from State 20c, LOCATION -205/PLACEAND DATE OF DISPOSITION DATE must Crownsville 4 Donation 5 Other (Specify) examiner 21. SIGNATURE OF FUNERAL SERVICE LICEASEE 22. NAME AND ADDRESS OF FACILITY vast Menue medical 23. PART I Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory street, shock, or part fellure. List only one cause on each line. IMMEDIATE CAUSE (Final the disease or condition___ event reaulting in deeth) HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed traumatic CERTIFICATION Sequentisity liet conditions. QUE TO (OR AS A CONSEQUENCE OF) if sny, lesding to immediate fre cause. Enter UNDERLYING CAUSE (Disesse or Injury other certificate has been signed by the attending phy the State Dept. of Health and Mental Hygiene 1, or item 23 shows any injury, or other that initiated events resulting in death) LAST PART II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 12 PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) HOSPITAL:
1 [2] inpetient 2 [] ER/Outpetient 3 [] DOA **EXAMINER?** OTHER: 1 YES 2 NO 4 Nursing Home 5 Residence 6 Other (Specify) 27. MANNER OF DEATH 28s. DATE OF INJURY (Month, Day, Yeer) 28b. TIME OF 28c. INJURY AT WORK? 28d, DESCRIBE HOW INJURY OCCURED is marked, 1 Natural 5 Pending Investigation М 1 YES 2 NO BY 2 Accident 28e. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify) 3 Suicide COMPLETED 8 Could not be DIRECTOR: A hours after d 4 Homicide 29e. CERTIFIER
(Chack onto)

1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. FUNERAL within 72 h IMPORTANT: IL 2 $\ \ \ \ \$ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER THE BEE Miran 23 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) RANDA wo ST. 0

32! HEGISTRAPIS SIGNATURED LIVE D'AUGUELLA NONLAU

3. TIME OF DEATH 2:01 B. BIRTHPLACE (State or Foreign 9c. COUNTY OF DEATH NA 10d. INSIDE CITY t YES 2 NO 10g. CITIZEN OF WHAT COUNTRY? 14. RACE — American Indian, Black, White, atc. Black 20002 Crownsville, MD Baltond ZIZIS Approximsta Onset and Death 24b. WERF AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 29d, DATE SIGNED (Month, Day, Year)



permit. Pages 1, 2, 3 should

be detached for use as the burial-transit

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AL D	0	2 40	IMPORTANT: If Item 28 is marked, or Item 23 shows, any Injury, or other traumatic event, the medical examiner must be notif
SPIT	VERA	nin 7	Ë
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2	2	8	Ξ
	TO THE HOSPITAL DR ATTENDING PHYSICIAN. The Jaw requires that the death certificate be executed within 24 hours after death. Page 6 may be ratal	TO THE HOSPITAL DR ATTENDING PHYSICIAN The Taw requires that the death certificate be executed within 24 hours after death. Page 6 may be retail TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 sh	TO THE HOSPITAL DR ATTENDING PHYSICIAN The Taw requires that the death certificate be executed within 24 hours after death. Page 6 may be ratal TO THE FUNERAL DIRECTOR: After this certificate has been symed by the attending physician and completely filled in by the funeral director, page 5 sh be filed within 72 hours after death with the State Deat, or Relath and Mental Hygiene prior to burial, cremation, or removal.

2

30. NAMÉ AND AUD

Joseph-

91995

31. DATE FILED (Month, Day, Year)

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH 15.1995 6:15 P M December JOSEPHINE WOODEN CALLAHAN 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF LINDER 24 HRS. 7. DATE OF BIRTH (Month, Dev. Year) BIRTHPLACE (State or Foreign
Country) DAYS HOURS 1 M 2 D 213-42-6767 10 Illinois 910 9s. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR KESWICK HOME Baltimore N/A 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland N/A Baltimore 1 1 YES 2 | NO 10e. STREET AND NUMBER FUNERAL 101. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 6 West Lake Avenue **USA** 21210 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☑NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, White, atc. If yes, specify Cuben, Maxican, Puerto Rican, etc.)

1 YES 2 NO Specify: 1 Never Married 2 7 Married BY 3 Widowed 4 Divorced Specify White 15. DECEDENT'S EDUCATION (Specify only highest grade COMPLETED 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working 16b. KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Residence Vrs 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) notified at Morris A. Wooden BE Jeanne Burke 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Callahan James F. 6 West Lake Avenue. Baltimore, Maryland 21210 9 20a, METHOD OF DISPOSITION
1 \(\text{A Burlal} \) 2 \(\text{Cremation} \) 3 \(\text{Ramoval from State} \) 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State must 4 Donation 5 Other (Specify) ey Mem. Grans 12/19
22. NAME AND ADDRESS OF FACILITY Dulaney Valley Mem. Timonium, Maryland 21093 21. SIGNATURE OF PUNERAL SHAPE SICENSEE

Multin D. Yawson examiner Mitchell-Wiedefeld Home 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate medical IMMEDIATE CAUSE (Finel Onset and Death the disease or condition einer S eare event, reaulting in death) Years DUE TO (OR AS A CONSEQUENCE OF) traumatic CERTIFICATION Sequentially liet conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury other DUE TO (OR AS A CONSEQUENCE OF): that initieted eventa resulting in death) LAST 6 Injury, PART II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part i. PHYSICIAN: MEDICAL 24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 24a. WAS AN AUTOPSY shows any 1 TES 2 THE 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES IN NO IN UNCERTAIN I 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) flem HOSPITAL: OTHER:
4 Nursing Home 5 - Residence 8 - Other (Specify) 1 TES 2 NO Inpetient 2 - ER/Outpetient 3 - DOA 6 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 28c. INJURY AT WORK? marked, 28d. DESCRIBE HOW INJURY OCCURED 1 M Natural 1 YES 2 NO BY 2 Accident 28s. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify) 3 Suicida 28t. LOCATION (Street and Number or Flural Floute Number City or Town, State) 69 COMPLETED 8 Could not be 4 Homicide 28 determined CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated. (Check only one) 2 MEDICAL EXAMINER: On the beam of examination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(a) and manner as stated. 29b. SIGNATURE TITLE OF CENTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, BE 9 95

WHO COMPLETED CAUSE OF/DEATH (ITEM 27) (Type, Print)

7801

York Road, Suite # 102, Towson,

M.D.,

DHMH-18 Rev 1/89

Maryland 21286

DHMH-16 Rev 1/89

1

FOR STATE REGISTRAR CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH Ellwood Ray Campbell December 19. 3:05 A. 4. SOCIAL SECURITY NUMBER 5. SEX 8. AGE (In yrs. last birthday) IF UNDER 1 YEAR | IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year) DAYS HOURS 220-09-8518 1 XM 2 | F JULY 24,1920 YRS. 75 Maryland Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY. TOWN OR LOCATION OF GEATH Sc. COUNTY OF OEATH DIRECTOR 6207 Elmbank Avenue Mt. Washington Baltimore County RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Baltimore County Mt. Washington permit. 1 YES 2 700 FUNERAL 10s. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? uted within 24 hours after death. Page 5 may be retained by the hospital or attending physician. completely filled in by the funeral director, page 5 should be detached for use as the burial-transit 6207 Elmbank Avenue 21209 U.S.A. 13. WAS OECENDENT OF NISPANIC ORIGIN? (Specify Yes or NoIf yes, specify Cuben, Mexican, Puerto Rican, etc.)

1 YES 2 NO Specify: 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ▼ YES 2 □ NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 14. RACE — American Indian, Black, White, etc. BALTIMORE, MARYLAND 21215-0020 1 Never Married 2 X Married Specify: White BY 3 Widowed 4 Divorced World War II ETED 16e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working 15. OECEDENT'S EDUCATION (Specify only highest grade complete 16b. KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5+) COMPL 12 Recreational Director City Dept. Parks & Recreat. once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Meiden Sumame) notified at Raymond Campbe 11 Pear1 BE Mixture 19s. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 Catherine M. Campbell 6207 Elmbank Avenue, Baltimore, Maryland 21209 2 12/20 Baltimore, Maryland 20e. METNOD OF DISPOSITION
1 ☐ Burial 2 Cremetion 3 ☐ Ramoval from State 20b. PLACE AND DATE OF DISPOSITION (Name of must Green Mount Crematory 4 Donation 6 Other (Specify) medical examiner 21. SIGNATURE OF FUNERAL SERVICE LICENS 22. NAME AND ADDRESS OF FACILITY Mitchell-Wiedefeld Home, Inc. 6500 York Rd. Baltimore, Maryland 21212 23. PART / Enter the diseases, or compilications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximata shock, or heart fellure. List only one ceuse on each line. cremation, or IMMEDIATE CAUSE (Final Onset and Death the disease or condition resulting in death) traumatic event, hysician and com prior to burial, o CERTIFICATION Sequentielly list conditions, strined by the attending physician Hearth and Memal Hygiene prior to If any, leading to immediate the the death certificate be cause. Entar UNDERLYING other 1 CAUSE (Disease or injury DUE TO (OR AS A CONSEDUENCE OF) that initiated events resulting in death) LAST 6 Injury, PART II. Other significent conditions contributing to deeth but not resulting in the underlying cause given in Part I. 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 24s. WAS AN AUTOPSY PERFDRMED? MEDICAL any 1 TYES 2 NO OF DEATH? shows 1 YES 2 ND t. of DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: has by Dept. S DIVISION OF VITAL 25. WAS CASE REFERRED TO MEDICAL 26. PLACE DF DEATH (Check only one) HOSPITAL OR ATTENDING PHYSICIAN: The this certificate h HOSPITAL OTHER: 1 TES 2 ND Inpatient 2 - ER/Outpatient 3 - DOA 4 ☐ Nursing Nome 5 X Residence 6 ☐ Other (Specify) 10 27. MANNER OF DEATH 28s. DATE DF INJURY (Month, Day, Year) 28b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE NOW INJURY OCCURED marked. 1 X Natural 1 YES 2 ND After t ВУ 2 Accident 28s. PLACE OF INJURY — At home, larm, atreet, factory, offica building, atc. (Specify) .00 ETED 3 Sulcide 28I. LOCATION (Street and Number or Rural Route Number, City or Town, State) 6 Could not be DIRECTOR: / 4 Homicide 28 determined hours 29e. CERTIFIER (Check only Check only CERTIFVING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(e) and manner se stated. COMPL TO THE HOSPITAL OF THE FUNERAL DE FINE WITHIN 72 M (Check only one) 2 MEDICAL EXAMINER: Dn the beele of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner as stated. 29b. SIGNAPURE AND TITLE OF CENTURE 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE D33624 um mi December 19, 1995 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) John Downs, M.D. 7505 Osler Drive, Suite 504, Towson, Maryland 21204 32. REGISTRAR'S SIGNATURE 91995

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

ITEMS: 4b, 18, PER F. Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

FILM 6-730 12/19/95 t.t State of Maryland / Department of Health and Mental Hygiene 95

						Certificate of	Death		Reg. No.		
	Dhasia		1. Decedent's Name (First, Middle, L.	ast)				2. Date of Dee		Yeer	3. Time of Death
	Physic /Medi		EDWARD			COHEN		DEC.		95	7:50 PM
	Exami		4a. Facility Name (If not institution, gi				4b. City, Town, or PIKESVI	Location of Death		of Death	
	Funeral Director		5. Social Security Number 6.		yrs. last bir 5	thday) If Under 1 Year Months Deys	r if Under 24 Hrs	8. Date of Birt	h y, Year)	9. Birthp	pleca (Stete or Foreign ntry)
	he Maryland 18a-f show out ad at	Director	10e. State 10b. County MARYLAND B	ALTIMORE 100		or Location GS MILLS					10d. Inside City Limits 1 □XYes 2 □ No
	th with the		10e. Street end Number 4601 WATERFALL CC	URT , APT. T	-2	10f. Zip Code	21117		10g. Citizen of V USA	Vhet Cour	ntry?
	172 hours after death with the Manyland "naturel", or items 23a or 28a-f show solfiel Examine I must be notified at	by Funeral	11. Maritat Status 1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced	12. Was Decadant Ever Armed Forces? 1 Yes 2 No If Yes, Giva Year or Detes:	in U,S.	13. Was Decedent of If Yes, specify Cul		Specify Yas or No- to Rican, atc.)	Specify	ck, Whita,	can indien, etc.
	S 1 2	Completed	15. Decedent's E (Specify only highest gi Elementary/Secondary (0-12)	ducation ade completed) College (1-4or 5+)	16a.	Decedent's Usuel Occu (Give kind of work done life. DO NOT use retire	upation a during most of wo ed)	rking	16b. Kind of Bu	ısinass/In	dustry
	Hygi there	Be Con	12 17. Fether's Neme (First, Middle, Las			ADMINISTRAT		TANT ma (First, Middle,		OICAL	
	d 2 should be filed th and Mental Hygi 7 is marked other traumatic event,	To B	HYMAN	T-11-11-11		HEN		CNNIE		(03 -	KASSOFSKY
	is 1 and 2 st of Health and item 27 is n other traun		19e. Informent's Name/Relationship MRS. GERTRUDE	COHEN	46	Mailing Address (Stree		APT. T-	-2 OWING	S MI	LLS,MD
	of the second		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Oner (Speci	Removel from State	cametai	Disposition (Name of y, crematory or other plane) MORE HEBRE		Date -15-1995	20c. Location - REISTER		
	pemit. Pag Department important: i any inlury o		21. Signature of Europra's Service Lib	noticeflons that caused the	daath. Do i	6010	ress of Facility EVINSON &	BROS.,	INC.		MD 21215 Approximate
	Physician /Medical Examiner	Je.	Immediate Cause (Final disease or condition resulting in deeth)	. Multy	le	Lyupe consequence of):	e			-	Interval Between Onset and Death
	certificate be axecuted iding physician and use as the bunal-transit	Medical Examiner	Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Irijury that initiated events resulting in death) Lest	c		onsequenca of):					
	the death by the atter ached for u	Physician/N	Part II. Other significant conditions		23b. Did tobacco use contribute to the cause of deat						
1	aw requires as been sign 2 should be	Completed by							an autopsy rmed?	av	ere autopsy findings rallable prior to impletion of cause death?
	The ate h	@	25. Was case referred to medical				26 Plane of Do	ath (Check only o	res 2□No	19	Yes 2□ No
	Physician: this certific ral director,	0 0	exeminer? NOX es 2 □ No	Hospitel:	2 □ ER/Ou	tpetient 3 DOA	ther	lome 5 ☐ Resid		er (Snecii	SCENE
	After After	Certification: T	27. Manner of Deeth 1 Natural 5 Pending 25. Accident Investigation 3 Suicide 6 Could not be	28a. Dete of Injury (Month, Dey Yea	28b. 7	ime of 28c. Injury Wo			now injury occur	red Sy	The same of the sa
	E Dig		4 Homicide determined	building, etc. (Sp	oecity)	1		and forth	m, State) Ste	orive !	an Bellemon
	he Hospital in 24 hours he Funerel pletaly filled	edical	29e. Certifier 1 ☐ Certifying Pl (Check only one) 2 ☐ Medical Exa	nyaician: To the best of my minar: On the basis of exar and menner stated.	knowledge nination en	death occurred at the to for investigation, in my	ime, date and plece opinion, death occu	e, and due to the durred at the time, d	ceuse(s) and ma dete end plece,	inner ås s and due tr	tated. o the cause(s)
	To the To the Comple	M	29b. Signature and title of cartifier	Kind m			C.M.E.		29d. Data signe DECEMBE		i diam.
	O		30. Neme and address of person who THEODORE M,			Type, Print) nn Street	, Balti	more, M	Marylar	nd 2	1201
	Sta Registr	te ar	31. Date filed (Month, Dey, Year) DEC 1	32. Registre s S	ignature	sor Randall					

" " H I D C INC 20: X I S MIN I A IQ II

ITEM: 1. PER F.H. FILM G-730 12/19/95 t.t

	1 - FOR STATE REGISTRAR	STATE OF MARYL		MENT OF H		MENTAL HYGIEI					
	1. DECEDENT'S NAME (First, Middle, Last)	WANDA FRANCES	CLARK			2. DATE OF DEATH	DAY Y	3. TIME OF DEATH			
	4. SOCIAL SECURITY NUMBER		(In yrs. lest birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)	10.	BIRTHPLACE (State or Foreign Country)			
	212-34-9760	1 □ M 2 🔀 F	59 YRS.	WONTHS DAYS	HOURS MIN.		7, 636 MARYLAND				
_	9a. FACILITY NAME (if not institution, give s	treet and number)		9b. CITY, TOWN	OR LOCATION OF DE		9c. COUNTY				
DIRECTOR	Harbor Ho	spital		BALT	IMORE	N	N/A				
E	10a. STATE 10b. COUNTY		t0c. CITY,	TOWN OR LOCA				10d. INSIDE CITY LIMITS?			
		NNE ARUNDEL			VERN			1 TYES 2 NO			
FUNERAL	100. STREET AND NUMBER 34 BURNS CROSSING	ROAD		10	21144		_	N OF WHAT COUNTRY?			
BY FUN	11. MARITAL STATUS 1 Never Married 2 Merried 3 Widowed 4 Divorced	12. WAS DECEDENT EVER I FORCES? 1 YES IF YES, GIVE WAR OR D	27 NO	If yea, sp		NIC ORIGIN? (Specify Vin, Puerlo Ricen, etc.)	ee or No 14	Black, White, etc. Specify: WHITE			
COMPLETED	15. DECEDENT'S EDU (Specify only highest grade		tea. DECEDENT'S U	ork done durina mo		USINESS/INDUS					
Ę	Elementary/Secondary (0-12)	College (1-4 or 5+)	title. Do NOT use					MEDICAL			
ĬŽ	1.2 17. FATHER'S NAME (First, Middle, Lest)	N/A	ADMINIST	RATOR	Las accomplished has	ME (First, Middle, Maide	ENTER				
		DT	CH		FRANCES		,	DECKE			
BE	WILLIAM 19e, INFORMANT'S NAME (Type/Print)	RI		ADDRESS /Street		MARTHA Route Number, City or To					
5	DANIEL CLIFTON CL	ARK .TR	100000000000000000000000000000000000000			D, SEVERN		21144			
	20a. METNOD OF DISPOSITION	200	b. PLACE AND DATE OF			DATE 20c. L	OCATION — City	y or Town, State			
	20e. METNOD OF DISPOSITION 20e. METNOD OF DISPOSITION (Name of page 1) 20e. PLACE AND DATE OF DISPOSITION (Name of page 2) 20e. PLACE AND DATE OF DISPOSITION (Name of page 2) 20e. DETAIL DATE OF DISPOSITION (Name of page 2) 20e. DETAIL DATE OF DISPOSITION (Name of page 2) 20e. DETAIL DATE OF DISPOSITION (Name of page 2) 20e. DETAIL DATE OF DISPOSITION (Name of page 2) 20e. DETAIL DATE OF DISPOSITION (Name of page 2) 20e. DATE OF DISPOSITION (Name of page 2) 20e. DATE OF DISPOSITION (Name of page 2) 20e. DATE OF DISPOSITION (Name of page 2) 20e. DATE OF DISPOSITION (Name of page 2) 20e. DATE OF DISPOSITION (Name of page 2) 20e. DATE OF DISPOSITION (Name of page 2) 20e. DATE OF DATE OF DISPOSITION (Name of page 2) 20e. DATE OF DATE OF DISPOSITION (Name of page 2) 20e. DATE OF DATE OF DISPOSITION (Name of page 2) 20e. DATE OF DATE OF DATE OF DISPOSITION (Name of page 2) 20e. DATE OF DATE OF DATE OF DATE OF DISPOSITION (Name of page 2) 20e. DATE OF DAT										
	21. SIGNATURE OF FUNERAL SERVICE US		NERAL HOME,								
	► () - ta			RNIE, MD. 21061							
CERTIFICATION	IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that infiliated events resulting in death) LAST List only one cause on each line. Interval Between Onset and Death LO CALL C In Carcinoma DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):										
MEDICAL	PART II. Other algnificant condition					PERFO	IN AUTOPSY DRMED?	24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATIN? 1 YES 2 NO			
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL	KIBUTE TO CAUSE C	28. PLACE OF DEATI			ТА СП					
딣	EXAMINER?	HOSPITAL:		OTHER:	n E [] Basidanan	8 Other (Specify)					
¥	27. MANNER OF DEATH	28a. DATE OF INJURY	28b. TIME	OF 28c. IN	JURY AT	28d. DESCRIBE NOW	/ INJURY OCCUI	RED			
	1 Natural 5 Pending	(Month, Day, Year)	INJU		YES 2 NO						
TED BY	2 Accident Investigation 3 Suicida 8 Could not be 4 Homicide detarmined	28e. PLACE OF INJUR building, etc. (Spe	Y — At home, term, st ecify)	reet, tactory, offic	CID .	28t. LOCATION (Stree City or Town, Stat		Rural Route Number,			
111	29a. CERTIFIER (Check only one) 2 IMEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and menner as stated.										
JAMC	(Check only 1 DC CERTIFYING PNYS										
COMPLETED	(Check only 1 DC CERTIFYING PNYS	ER: On the beels of examination				time, data and place,	and dua to the o				
8	(Check only 1 CERTIFYING PNYS one) 2 MEDICAL EXAMINE	ER: On the beels of examination			death occured at the	time, data and placa,	29d. DATE S	SIGNED (Month, Day, Year)			
	(Check only 1 CERTIFYING PAYS ONE) 2 MEDICAL EXAMINE 29b. SIGNATUSE AND TITLE OF CERTIFSE SO PERSON WITH A SIGNATUSE AND ADDRESS OF PER	ER: On the basis of examination	eath (ITEM 27) (Type.	, in my opinion,	29c. LICENSE NUI	time, data and place,	29d. DATE S	signed (Month, Day, Year) mber 15, 1995			

DHMH-16 Rev 1/89



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed when 24 hours after death. Page 6 may be retained by the hospital or attending physician.

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IMPORTANT: If Nem 28 is marked, or Nem 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

	ITEMS: 1.18	.19b,	PER F.H. F	ILM G-730	12/19	/95 t	.t					9	5	38200
	FOR STATE REGISTRAR		STATE OF I	MARYLAND /		RTMEN ICATI				MENT	AL HYGIEN	-		
- 8	1. DECEDENT'S NAME (First									_ MOI		AY	YEAR	3. TIME OF DEATH
		APLAN	NORM					ember	14 19	V	2040 M			
ij	4. SOCIAL SECURITY NUMBER 217-18-3669		5. SEX	8. AGE (In yrs. las	YRS.	IF UNDER	DAYS	HOURS	24 HRS, MIN.	J. DAT	LY 29,	1912		YLAND
OR	90, FACILITY NAME (If not in SINAI HOSPI	TAL	street end number)			96. CITY, TOWN OR LOCATION OF DEATN BALTIMORE						sc. county of death N/A		
2	RESIDENCE OF DEC	10b. COUNT	Υ		10c. CI	TY, TOWN	OR LOCAT	ION						10d, INSIDE CITY
L DIRECTOR	MARYLAND		I/A				ALTI	MORE					LIMITS? 1 XYES 2 NO	
FUNERAL	2905 FALLSTAFF RD., APT. 25						101	212		10g. CITIZEN OF WHAT USA				
B	11. MARITAL STATUS 1 Never Married 2 3 Wildowed 4 Divo		FORCES?	DENT EVER IN U.S. ARMED 1 YES 2 NO E WAR OR DATES 13. WAS DECENDENT OF NISPANITY YES, specify Cuben, Mexica 1 YES 2 NO Specify 1 YES 2 NO Specify					n, Puer		e or No—	14, RAC Blec Spec	E — American Indian, k, White, etc.	
COMPLETED	15. DEC (Specify onl Elementary/Secondary (f	ive kind of Do NOT L	Work done	during mo	ON ist of worki	ng		isb. KIND OF BU		J HOM	10			
MP		.2		I	HOMEN	1AKER								
BE CO	17. FATNER'S NAME (First, M SAMUEL				AUERI						HANDLER			NOVN
TO	190. INFORMANT'S NAME (PLAN	19	650	3 TRC	S (Street a	DD CC	r or Rural F	BAI	umber, City or To	, MD	(p Code) 2120	9
MR. ROBERT H. CAPLAN 20s. METHOD OF DISPOSITION 1 Device 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20s. METHOD OF DISPOSITION (Name of competition) Removal from State 20s. DATE 20s. LOCATION - City of Competition (Name of competition) Removal from State										JDALI	STOWN, MD			
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN ROAD BALTIMORE, MD 21215													
CERTIFICATION	IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST Onset and Death Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):													
MEDICAL CE	PART II. Other significa	ant condition	ns contributing to	o death but not	resulting	in the u	nderlyln	g ceuse	givan in	Part I.	24s. WAS AI PERFO	RMED?	240	b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATN?
PHYSICIAN: M	DID TOBACCO L 25. WAS CASE REFERRED TO		RIBUTE TO CA			ES ATN (Check			CERTAI	N 🗆				1 U YES 2 NO
SIC	1 Tes 2 No		HOSPITAL:	☐ ER/Outpatient	3 🗆 DOA	OTHE 4 Nu	R: rsing Hon	ne 5 □ R	esidence	8 🗆 0	ther (Specify)			
ВУ РНУ	/	Pending Investigation	28e. DATE O (Month,	F INJURY Day, Year)	28b. TI		28c. IN.	JURY AT ORK? YES 2 [_	DESCRIBE NOW	INJURY O	CCURED	
0	2 Accident 3 Suicide 6 4 Nomicide	Could not be determined	28e. PLACE building	OF INJURY — At h	ome, term,	street, fed	ctory, offic	:0		28t. L	OCATION (Street City or Town, State	end Numb	er or Rural	Route Number,
COMPLETE	29e. CERTIFVING PNYSICIAN: To the best of my knowledge, death occurred at the time, date end piace, end due to the cause(e) end manner es stated. (Check only one) 2 MEDICAL EXAMINER: On the best of exemination end/or investigation, in my opinion, death occurred at the time, date end piace, end due to the cause(e) end manner es stated.													
00						ion, army	ориноп, с							
TO BE	296. SIGNATURE AND TITLE	Seva	MD.						HOZA:		5 2931			o (Month, Day, Year) Ler 14, 1995
É	VALERIE ST	F PERSON WI	SINAL F	USP 2	M 27) (Typ	Beli	/edev	c K	lvc	\mathcal{B}	S 2931 alterno	12 ,	4D.	
	31, DATE FILED (Month, Day, DEC 1	9 1995		WILLIAM RANGE	lett.									
	•		0-		1 1	,								DNMH-16 Rev 1
1														



BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

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IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REG. NO.												
	1. DECEDENT'S NAME (FIRST KATHLEEN		BETH COMB	S						2. DATE OF DEATH DOOR DECEMber	Ĭ7, :	1995	3. TIME OF DEATH
	4. SOCIAL SECURITY NUMBER	BER	5. SEX	6. AGE (In yrs. les	t birthday)	IF UNDER	1 YEAR	IF UNDER	R 24 HRS.	7 DATE OF BURTH			IPLACE (State or Foreign
	226-09-8557	7	1 M 2 TyF	7,	YRS.	MONTHS	DAYS	HOURS	MIN.	(Month, Day, Year) September	13	1921	
1 3	90. FACILITY NAME (# not in		21		7								
Œ												EATH	
2	6405 Hartwa	alt St	•			Baltimore City N/A						N/A	
Diameter 1	10a. STATE	10b. COUNT	Y		10c. CITY, TOWN OR LOCATION							10d. INSIDE CITY	
DIRECTOR	Maryland	N/A				ltimo						- 1	LIMITS?
	10a. STREET AND NUMBER					101, ZIP CODE					1 🔀 YES 2 🗌 NO		
FUNERAL	4405				2 2223					1-41			
2	6405 Hartwa	lit St	1				_	<u> 2122</u>					States
3	1 Never Merried 2 反	Married	12. WAS DECEDENT FORCES? 1	EVER IN U.S. AR	MED IO					IIC ORIGIN? (Specify Yes	or No-	14, RACE Black	— American Indian, k, White, atc.
BY	3 Widowed 4 Divo		IF YES, GIVE WI	AR OR DATES			1 YES	2 XNO	Specify		1	Special Whi	
	15 DEC	EDENT'S EDU	ICATION	10- DE	CEDENT'S	1101144 0	201124						
COMPLETED	(Specify only	y highest grade	completed)	(G	ve kind of a	work done	during mo	st of world	ing	16b, KIND OF BU	JINESS/INC	DUSTRY	
12	Elementary/Secondary (6	0-12)	College (1-4 or 5+))						D 4			
\ <u>\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\</u>	6 th	liddle Leet		l wa:	itres	SS				Resta		CS	
H	19a, INFORMANT'S NAME (
임	Lester A. (190	S. MAILING	How t	(Street a	nd Number	r or Rural F	noute Number, City or Tow	n, State, Zig	Code)	21224
	20a. METHOD OF DISPOSIT								• De				
	1 Donation 5 Other	n 3 🗆 Rem	ioval from State	cemetery, cae	matory or o	of Dispos they place) 5 Laus	TION (No	meol mete:	ry :	0ATE 200. LO	CATION - Balt:	imore	e City, MD
	21. SIGNATURE OF PUNERA	L SERVIGE LI	CENSEE /	///	/	_	_						
	22. NAME AND ADORESS OF FACILITY Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222												
23. PART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or resolvatory except													
	snock, or n	een tellure.	List only one caus	e on each line		iot enter	tile mo	de oi dy	ing, suci	i as cardiec or respi	ratory sn	rest,	Approximats Interval Between
	IMMEDIATE CAUSE (Fir disease or condition	nel	9.2	Acres.				111					Onset and Death
	disease or condition a. Due to (or as a consequence of):										1 MUNTR		
1_1		_	DOE 300	OH AS A CONSEC	DUENCE OF	-):							
CERTIFICATION	Sequentially list conditi	lona,	b. DUE TO (OR AS A CONSEC	UENCE O	j:							
I &	cause. Enter UNDERLYI	ING	c										!
Ē	CAUSE (Disesse or Inju that initiated events		DUE TO (OR AS A CONSEC	UENCE O	j:							
ᇤ	resulting in death) LAS	T	d										
	BART II Other elevities	-4 1101											
EDICAL	PART II. Other significe	onaltion	na contributing to d	deeth but not n	eaulting	n the un	derlying	ceuse	given in i	Part I. 24s. WAS AN PERFOR			WERE AUTOPSY FINDINGS
음										1 YES 2	NO		OF DEATH?
M										/			1 YES 2 NO
	DID TOBACCO U	SE CONT	RIBUTE TO CAU	JSE OF DEA	TH YE	S 🗆 t	10 E	UNC	ERTAIN				
ı ×	25. WAS CASE REFERRED TO EXAMINER?	D MEDICAL		28. PLAC	E OF DEAT	H (Check	only one)		1				
S	1 TES 2 DO		HOSPITAL:	ER/Outpatient 3	□ DOA	OTHER		5 R	esidence	6 Other (Specify)			
PHYSICIAN	27. MANNER OF OEATH		28a. OATE OF I	NJURY	28b. TIM	E OF	28c. INJ	URY AT		28d. DESCRIBE HOW II	NJURY OC	CURED	
ВУР		Pending Investigation	(Month, Dey	/, 1 0 8/)	INJ	URY M		RK?	□ NO				
	2 ACCIONN	Could not be	28e. PLACE OF	INJURY — At hor	na, ferm, s	treet, fact	ory, office			261. LOCATION (Street a	and Number	or Rural R	oute Number,
ETED		determined	building, a	tc. (Specify)						City or Town, State)			
	290. CERTIFIER 1 CERT	IFYING PHYS	CIAN: To the best of n	ny kaomindan day	th conve	al an the st	4-1-	and also	200	to the cause(s) end man			
COMPL										to the cause(s) end man tima, data and place, an			
8							pinion, di				J due to th	e cause(s)	end manner as stated.
H	296. SIGNATURE AND TITLE OF CERTIFIER 296. LICENSE NUMBER 296. LICENSE NUMBER 296. DATE SIGNED (Month, Day, Year)								(Month, Day, Year)				
인	Mure	NOY	prysia	ian				PI	971	7	-/-	1419	/
	30. NAME AND ADDRESS OF	PERSON WH			1 27) (Type,	Print)		- 1 -		1 01	^		1
	MILTARL	FV	1-Tell (HOOM	L '	177	0 9	AlH	enw	NVE ITAL	1/NOX	o pu	22/224
	DEC. 10 10	- 1	32 REGISTRAR	SOGNATURE							7		
	22018 13	95	~~~~										



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BALTIMORE, MARYLAND 21215-0020	ath. Page 6 may be retained by the hospital or attending physician.	s certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should	
BA	24 hours after de	filled in by the fu	on, or removal.
DIVISION OF VITAL RECORDS, P.O. BOX 6876	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely 1	he first within 72 hours after death with the State Dent, of Health and Mental Hydiene prior to burial, cremation, or removal,

	1 - STATE REGISTRAR	UF MARYLAND (UEPAR ERTIF					TAL HYGIENI REG. NO.		
	1. DECEDENT'S NAME (First, Middle, Last) Clayton Chittam	5					M	ATE OF DEATH		year 3. TIME OF DEATH
	4. SOCIAL SECURITY NUMBER 5. SEX 1 X M	6. AGE (In yrs.	last birthday) YRS.	IF UNDER	-	UNDER 24 I	HRS. 7. D	ATE OF BIRTH fonth, Day, Year)	1.0	BIRTHPLACE (State or Foreign Country) WASH D.C.
	Sa. FACILITY NAME (If not institution, give alreet and nu		1110.	9b. CITY,	TOWN OR L	OCATION	OF DEATH	08/01/54		Y OF DEATH
0 R	BAYVIEW MEDICAL CENT	ER		B	AL TO.					
DIRECTOR	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY		10c. CIT	Y, TOWN O	R LOCATION	i i				tod. INSIDE CITY
	MD 10e, STREET AND NUMBER			BALTO						1X YES 2 NO
UNERAL	5526 CEDONIA AVE				101. ZN	P CODE	2		10g. CITIZE	N OF WHAT COUNTRY?
FUNI	11. MARITAL STATUS 12. WAS	DECEDENT EVER IN U.S.		13. \	MAS DECENT	DENT OF I	HISPANIC OF	RIGIN? (Specify Yee		4. RACE — American Indian, Black, White, atc.
BY		, GIVE WAR OR DATES						, , , , , , , , , , , , , , , , , , , ,		Specify: BLACK
ETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working					16b. KIND OF BUS	SINESS/INDUS	
P.E.	Elementary/Secondary (0-12) College	(1-4 or 5+)	(DRI		DELIVE	ERY)		BALT	o. CI	TY SCH. SYS.
once. COMPL	17. FATHER'S NAME (First, Middle, Lest) 16. MOTHER'S NAME (First, Middle, Maiden Surname)									
TO BE	FRANK MOBUARY 196. INFORMANT'S NAME (Type/Print) 196. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zio Code)									
TO TO	MECHEL CHITTAMS 5526 CEDONIA AVE BALTO, MD. 21206									
ust be	20b. PLACE AND DATE OF DISPOSITION DATE 20b. PLACE AND DATE OF DISPOSITION (Name of cemetary, crematory or other place)									
medical examiner must	4 Donation 5 C Other (Specify). 21. SIGNATURE OF EDNERAL SERVICE LICENSEE	I FT.	LINC	22.	EMET	ADDRESS				
ехаші	- Beroad 1	yell	_		-		-	& Son Fu hts Ave.		Home, Inc. o. Md. 21207
or other traumatic event, the	23. PART I. Enter the disease of or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failura. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentisity list conditions, if smy, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST Approximation and precursor respiratory arrest, paper interest that cause of a consequence of the cause of the disease of									
shows any injury, o	PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Chromic renal failure, ethanol abuse 24s. WAS AN AUTOPSY PINDIN AMILBLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 yes 2 No									
23 X	DID TOBACCO USE CONTRIBUTE 25. WAS CASE REFERRED TO MEDICAL		EATH Y			UNCE	RTAIN [
or item YSICI/	EXAMINER? † YES 2 NO 1 Input	TAL: tlant 2 - ER/Outpatient	3 DOA	OTHER 4 Num		5 🗆 Rasid	lenca 6 🗆	Other (Specify)		
P. P.	27. MANNER OF DEATH 28a Natural 5 Pending	DATE OF INJURY (Month, Day, Year)	28b. Till IN	ME OF JURY	28c. INJURY WORK		(4.5.	. DESCRIBE HOW I	NJURY OCCU	PRED
28 is mar TED BY	Accident Investigation 3 Suicide 6 Could not be determined	PLACE OF INJURY — At building, atc. (Specify)	t home, term,	atreat, fact		2	_	LOCATION (Street a City or Town, State)	and Number o	t Rural Route Number,
It item	29a. CERTIFIER (Check only one)									
p= 1	2 MEDICAL EXAMINER: On the	seed of exemination and	or investigati	on, in my o			at the time,	data and place, an		cause(a) and manner as stated. SIGNED (Month, Day, Year)
MPOR O BE	Steve Ile	u				-	4008	3	▶ 17	2/15/25
2	30. NAME AND ANDRESS OF PERSON WHO COMPLE	TEN CAUSE OF DEATH (ITEM 27) (Typ	e, Print)	Eask					
	31. DATE FILED (NATE Day bear 9 1995) 32	ELISTRA SICHATUR	River	40 (EU7K	m	nuen	ne		
	7			1						

EAT in increase

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1. 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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Natural
Accident

3 Suicide

4 Homicide

BY

COMPLETED

BE

2

										95	38	8203
	FOR STATE REGISTRAR	STATE OF 1					EALTH A		IENTAL HYGIEI REG. NO			
	1. OECEDENT'S NAME (First, Middle, Last) Car:	son Woo							2. DATE OF DEATH	DAY	1995	3. TIME OF OEATH 10:30 A M
	4. SOCIAL SECURITY NUMBER 220-03-0923	5. SEX 1 XM 2 F	8. AGE (In yrs. less	YRS.	IF UNDER	DAYS	IF UNDER 2	MIN.	7. DATE OF BIRTH (Month, Day, Year) OCT 27, 1		8. BIRTH Count	HPLACE (State or Foreign
TOR	99. FACILITY NAME (If not institution, give standard to the st	treet and number)			Seve		R LOCATIO	N OF DEA	ATH		e Aru	
DIRECTOR	Maryland Anne A	Arundel		10c. CIT	Y, TOWN O		R LOCATION Severn					10d. INSIDE CITY LIMITS? 1 YES 2 NO
FUNERAL	100. STREET AND NUMBER 1242 Delmont Road		IT EVER IN U.S. ARI								USA	WHAT COUNTRY?
B	11. MARITAL STATUS 1 Never Merried 2 Merried 3 Nicolar Annual Divorced	IMED NO		If yes, spe	ENDENT OF ecity Cuben, 2 X NO	, Mexicen,	C ORIGIN? (Specify Ye, Puerto Rican, etc.)	a or No-	14. RACE Black Speci	E — American Indian, k, White, atc. #y: White		
COMPLETED	15. OECEDENT'S EDUC (Specify only highest grade Elementary/Secondary (0-12)	+) (Gi	live kind of v . Do NOT us	NT'S USUAL OCCUPATION of of working of working of use relired.) 16b. KIND OF BUSINESS/INDUSTRY 16c. KIND OF BUSINESS/INDUSTRY Maryland Ship Bu								
BE COM	17. FATHER'S NAME (First, Middle, Lest) Luther E. C1	lark	DLOI	EXCE	per		16. MOTHE		Marylar E (First, Middle, Meide illie M.	Surneme)		Jilding
TO B	190. INFORMANT'S NAME (Type/Print) Olwin Pauline Clar	ck						or Rural Ro	oute Number, City or To	vn, State, Zi	ip Code)	
	20a. METHOD OF DISPOSITION 1		20b. PLACE A cometery, crer Metro	AND OATE O	of DISPOS other place) atory	y, I	me of nc. 1	2/19	0ATE 20c. LO	ocation ltimo	•	
	Dawn F. McDonald Cremation Society of Maryland, Inc.											Inc. 21228
	23. PART I. Enter the diseases, or complications that caused the death. Do not anter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Finel disease or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF):											Approximate Interval Between Onset and Daath
ERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	c	(OR AS A CONSEO	111111111111111111111111111111111111111								
PHYSICIAN: MEDICAL CE											. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO	
CIAN	DID TOBACCO USE CONTR 25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:			TH (Check o	, ,	UNCE	RTAIN				
HYSI	1 U YES 2 NO 27. MANNER OF DEATH			28b. TIMI		9: sing Home 26c. INJU WOI	JRYAT		Other (Specify) 26d. DESCRIBE HOW	INJURY OC	CURED	

М 1 YES 2 NO 28e. PLACE OF INJURY — At home, ferm, street, factory, office building, etc. (Specify)

281. LOCATION (Street end Number or Rural Route Number, City or Town, State)

29e. CERTIFIER CERTIFYING PHYSICIAN: To the best of my viedge, death occurred at the time, date end place, end due to the cause(a) and manner ee stated. (Check only one)

on, in my opinion, death occured at the time, date end place, end due to the cause(s) end menner eg stated, 29c. LICENSE NUMBER 29d. DATE SIONED (Month, Day, Year)

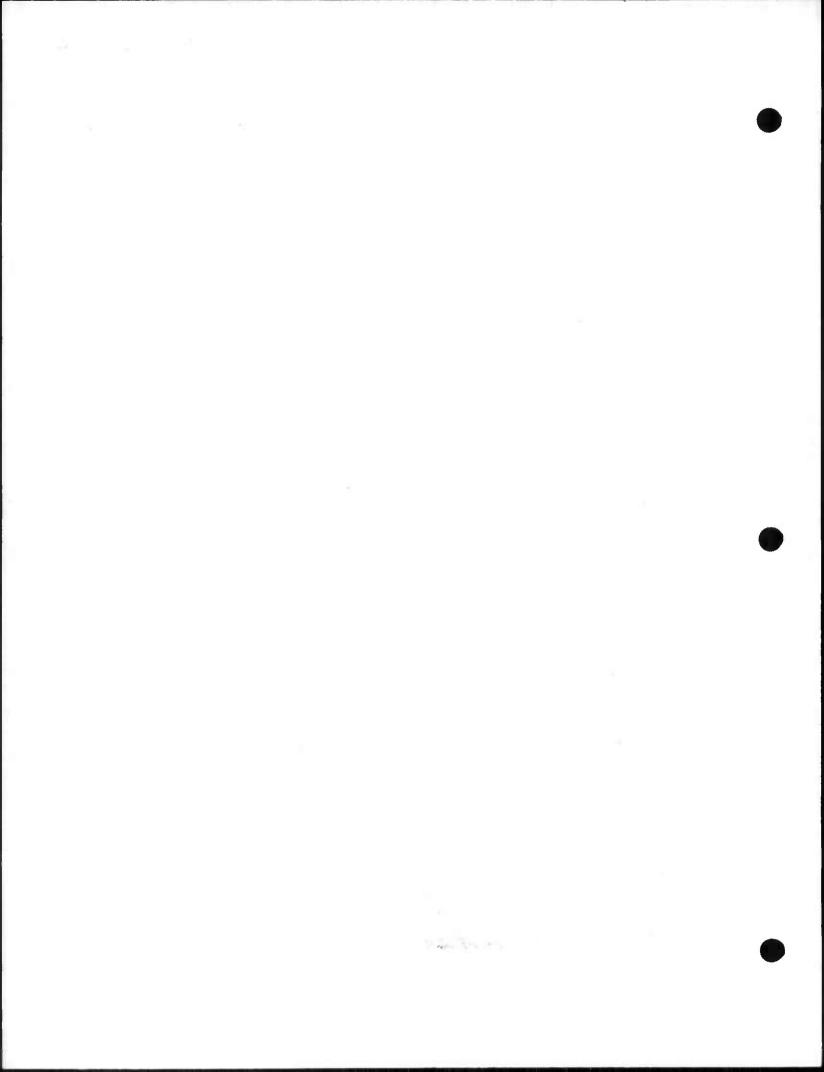
Highway

WHO COMPLETEO CAUSE OF DEATH (ICEM 27) (Type, Print)

1995

6 Could not be

DHMH-16 Rev 1/89



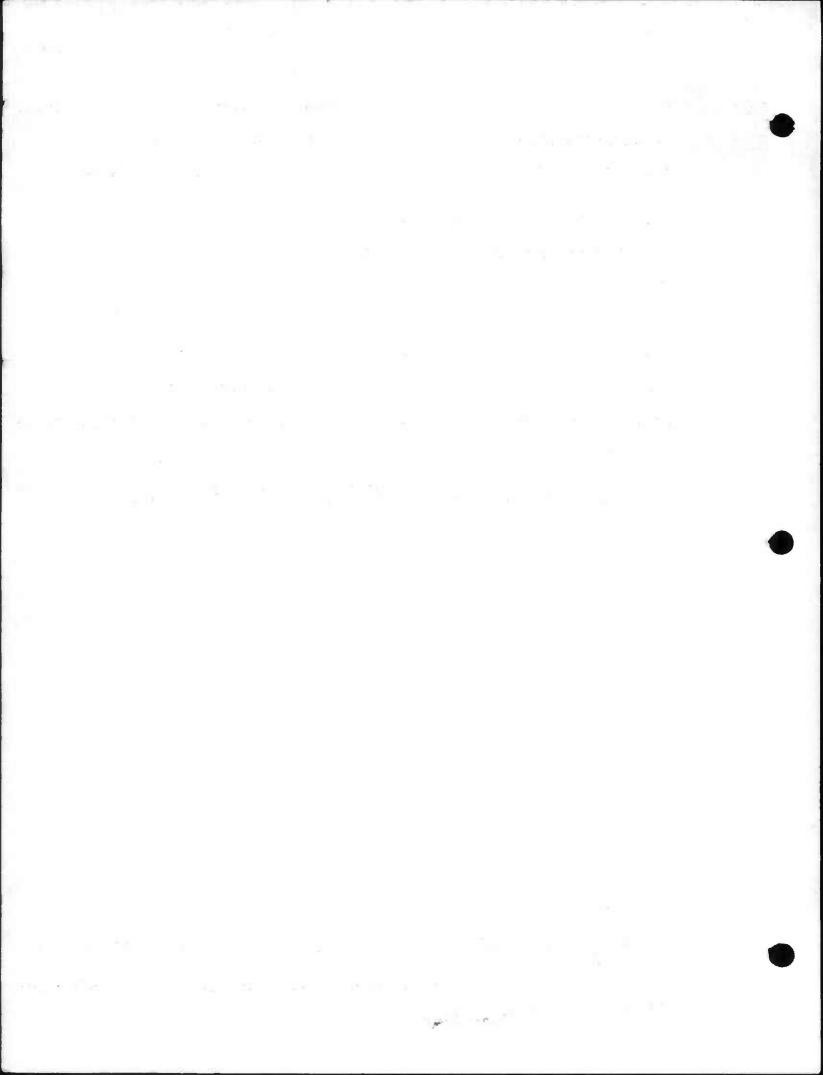
BALLIMORE, MARYLAND 21215-0020	hours after death. Page 6 may be retained by the hospital or attending physician,	his certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1.2.3 should	Or removal.
Civilian of VIIAL RECORDS, P.O. BOX 68760	TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled	be filed within 72 hours after death with the State Dept, of Health and Mental Hydiene prior to burial, cremation, or removal.

	FOR 1 - STATE REGISTRAR	STATE OF MARY	LAND / DEPAR CERTIF	TMENT OF HEALTH AN	MENTAL HYGIEN						
	1. DECEDENT'S NAME (First, Middle, Last) AGNES Orlea	an	CAR	LOTTA	2. DATE OF DEATH	1995 YE	3. TIME OF DEATH 9:13 AM				
	4. SOCIAL SECURITY NUMBER 216 - 16 - 9221 9a. FACILITY NAME (If not Institution, give si	The second secon	74 YRS.	F UNDER 1 YEAR F UNDER 24 HR MONTHS DAYS HOURS MIN	February		Maryland				
TOR	Saint Joseph Medic			96. CITY, TOWN OR LOCATION OF TOWBON, Mar		9c. COUNTY					
DIRECTOR	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY	1	10c, CIT	Y, TOWN OR LOCATION			10d. INSIDE CITY				
		larford	Fo	orest Hill			LIMITS?				
FUNERAL	100. STREET AND NUMBER	5		10f. ZIP CODE			OF WHAT COUNTRY?				
ONE	1612 Honeysuckle	12. WAS DECEDENT EVER	IN U.S. ARMED	21050	PANIC ORIGIN? (Specify Ve		S.A.				
B	1 Never Married 2 Married 3 Widowed 4 Divorced	FORCES? 1 TYES		13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No— If yes, specify Cuban, Maxican, Puerto Rican, etc.) 1 YES 2 XI NO Specify: White							
TED	15. DECEDENT'S EDUC (Specify only highest grade	CATION completed)	16a. DECEDENT'S (Give kind of s life. Do NOT us	USUAL OCCUPATION work done during most of working	16b. KIND OF BU	SINESS/INDUSTI					
COMPLET	Elementary/Secondary (0-12)	College (1-4 or 5+)	Homen	,	Own Home						
ÖM	17. FATHER'S NAME (First, Middle, Last)		1 Hollie		NAME (First, Middle, Maiden						
BE (Olando Moore	(/)-		Louise Campbell							
0	19b. MAILING ADDRESS (Street end Number or Rural Route Number, City or Town, State, Zip Code)										
	20e. METHOD OF DISPOSITION	20	_	Same as 10e	DATE 20c, LO	CATION City					
	1 X Buriel 2 Cremetion 3 Remo	oval from State	metery, cremetory or o	Redeemer Cemet	erv 12/19/9	5 Balt	imore, Mary				
	21. SIGNATURE OF FUNERAL SERVICE US	C. L. J.	-	Leonard J.	Ruck Funera	l Home,	Inc.				
	23. PART i. Enter the diseases, or c	complications that cause	ed the death. Do r	1 5305 Harfor	d Road Balt	imore,	Maryland 212				
	23. PART I. Enter the diseases, or complications that caused the death. Do not anter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. Elst only one ceuse on each line. IMMEDIATE CAUSE (Final disease or condition paulting in death) INFARCTED BOWEL										
2	resulting in dashi)		A CONSEQUENCE OF	NASCULAR COAG	BULATION		1 DAY				
CATIO	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING	CHRONIC C	A CONSEQUENCE OF	VE PULMONARY D	SEASE		10 YEARS				
CERTIFICATION	CAUSE (Disease or Injury that initiated events resulting in death) LAST C. DUE TO (OR AS A CONSEQUENCE OF): ISCHEMIC HEART DISEASE										
	PART II. Other significant conditions	s contributing to death	but not resulting	n the underlying cause given	In Part I. 24s. WAS AN	AHTOREY	24b. WERE AUTOPSY FINDING				
EDICA					PERFOR	MED?	AMILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH?				
Σ.	DID TOBACCO USE CONTR	RIBUTE TO CAUSE (OF DEATH YE	S NO UNCERTA	AIN IXI		1 WES 2/ NO				
CIA	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	AOSPITAL:	26. PLACE OF DEAT	'H (Check only one)							
PHYSICIAN:	1 TYES 2 NO 27. MANNER OF DEATH	t/Ovnpetient 2 ☐ ER/Out		OTHER: 4 Nursing Home 5 Residence							
BY PH	1 Natural 5 Pending Investigation	28e. DATE OF INJURY (Month, Day, Year)	INJ	WORK? M 1 YES 2 NO	26d. DEŞCRIBE HOW I	NJURY OCCURE)				
ETED	3 Suicide 8 Could not be datermined 28a. PLACE OF INJURY — At home, tarm, street, factory, office building, atc. (Specify) 28a. PLACE OF INJURY — At home, tarm, street, factory, office building, atc. (Specify) 28t. LOCATION (Street and Number or Rural Route Number, City or Town, State)										
COMPLET				ed at the time, date end place, and on, in my opinion, death occured at t			se(e) and manner es stated.				
O	296. SIGNATURE AND TITLE OF CERTIFIER	2		29c. LICENSE N	IUMBER	29d DATE SIG	NED (Month, Day, Year)				
H			-	D 4190	11	N 12	11/16				

31 DEC1 1971995

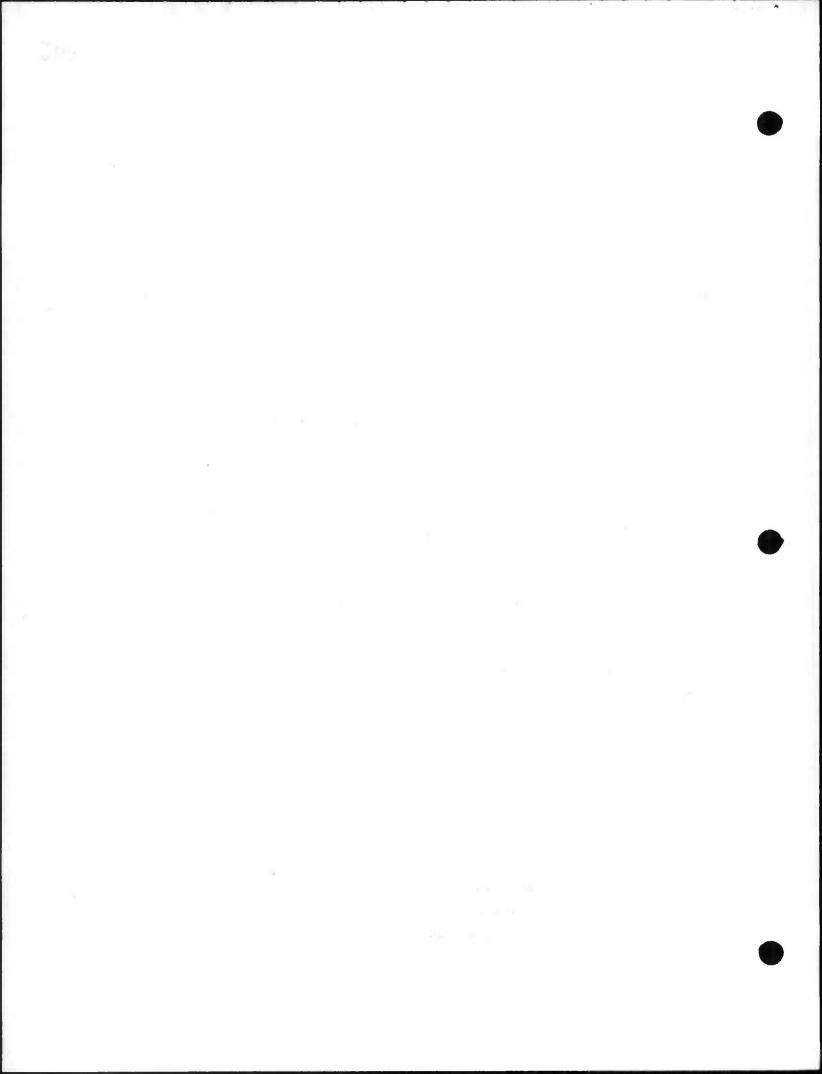
DHMH 16 Ray 6/95

_	Item23a, Per Med	27, Ex			Marylar	nd / Depa	artmen <i>rtificat</i>	t of F e of	lealth a Death	and N		ene フ	J	88205	
ı	Physic	ian	Decedant's Nama (First, Middla, La	st)							2. Date of Death Month	Day	Year	3. Time = Death	
6	. /Medi	cal	TYE		-1			COBB DE				17	95	9:02P.M.	
7	Exami	ner	4a. Facility Name (If not Institution, given 810 N.PAYSON S		7)			-	BALT	21.11					
1	Funerai		5. Social Security Number 6. S		Aga (In yrs.	last birthday)	If Under		If Undar	24 Hrs.	8. Deta of Birth	place (Stete or Foraign			
	Director		258-38-4429 Usual Rasidanca of Dacadant	I⊊M 2□F	67	Yrs.	Months	Deys	Hours	Min.	08/12	2/28	GE	ORGIA	
	r 28a-f ehow	_	10a. Stata 10b. County			ty, Town or Lo								10d. fnside City Limits	
	he M	Director	MD • N/A		BA	LTIMO								1 Yas 2 No	
	With the or		810 PAYSON	STREET			10f. Zip	217					0g. Citizan of What Country? USA		
	deeth	Funeral	11. Marital Status	12. Was Dacedar	nt Evar in L	J,S. 13.	Was Deced	dent of Hispanic Origin? (Specify Yes or No-				ice - Ameri	can Indien,		
21215-0020	72 hours efter deeth with the Meryland natural', or fterna 23a or 28a-f show dreal Examinet must be notified at	by	1 Never Merried 2 Marriad 3 Widowed 4 Divorced	Armad Forces 1 Yes 2 If Yes, Giva Yeer or Detes	No			specify Cuben, Mexican, Puàrlo Rican, atc.) s 2 XNo Specify:			Rican, atc.)	Speci	eck, Whita, ify: BI	atc.	
5-0	OI 85 69	Completed	15. Decedant's E (Specify only highast gra			16a. Dece	dant's Usua	I Occup	etion	of work	16b. Kind of				
121	within 7; ene. than "ra	mple	Elamantary/Secondary (0-12)	Collaga (1-4o	r 5+)	(Giva kind of work dona during most of work lifa. DO NOT usa retired)									
			9th 17. Fathar's Nama (First, Middla, Last,			TRU	CKER		19 Moths	r'a Nam	a (First, Middla, M	UNK	mal		
Maryland	o d at o	o Be	TOM COBB	·			LILLIE N					EW	maj		
ary	d 2 should b th end Ments 7 is marked traumatic e	L C	19a. Informant's Name/Ralationship (Type, Print)								n, Stata, Zii	p Code)		
	is 1 and 2 if Health e item 27 la other trai		IRIS M. TORR	ENCE	201	753	3 D,	WE			ORN WAY	, COL	UMIA	,MD.2104	
10	0 = = 0		20a. Mathod of Disposition 1									Oc. Location			
Baltimore,	permit. Per Departmen Important: any injury		4 Donation 5 Other (Specifical Service Licer	· ·	M						1–95	CATON	SVIL	LE. MD.	
Ba	Deport Impo		21. Signature of Funeral Service Licensee 22. Nama and Address of Facility ALBERT P. WYLIE F/ 638 N. GILMOR STREE									PA 21	217		
68760,	Physician /Medicale personnel estamine transition personnel person	\/Medical Examiner	Immediata Causa (Final disaasa or condition rasulting in daath) Sequantially list conditions, if any, laading to immediata cause. Entar Undartying Cause (Disaasa or injury that initiated avents rasulting in daath) Lest	a. HEAD	Dua to (d	Y COMPLIANCE OF AS A CONSECUTION AS A CO	quance of):		OHOL IN		CATION	began			
Box	death e etter	iclar	Part II Other elanificent conditions	ontributing to death	but not rec	ulting in the u	n do dulno a		an la Dari I		22h Did tol			a the source of death?	
s, P.O.	that the	by Physiclan/M	Partition of Significant Conditions C	ontributing to daath	ntributing to death but not rasulting In tha undarlyIng causa givan In Part I.					23b. Did tobacco use contribute to the cause of			bebly 4 Unknown		
Vital Records	e law requir hes been s je 2 should	Completed b									24a. Was ar	TYPL	cc of	Vara autopsy findings vallabla prior to omplation of cause daath?	
ta	dcian: The	Be Co	25. Was casa rafarred to medical						26 Diana	of Dogs	h (Check only one	s 2 No	11	∐Yas 2□ No	
	00	To B	axaminar? XXYas 2□ No	Hospital:	tient 2	ER/Outpatian	nt 3□ DC	A Oth	0.61		ma 5 Rasida		her (Specia	fy)	
0 _	ng Ph ther thi		27. Manner of Daath 1 ☐Natural 5 ☐ Panding	28a. Data of In (Month, D	jury lay Year)	28b. Tima of Injury	2	8c. Injun Worl			28d. Dascribe ho				
sio	Attending or death.	cati	2000 Accidant Invastigation 3 Suicida 6 Could not be			7;45 F			Yas 2 XX	Vo	SUBJECT FI				
Division of	al or Attending is after death. No Director: After ed in by the fune	Certification:	4 ☐ Homicida datarminad	28a. Placa of It building, a 810 N.	njury - At h atc. <i>(Spacil</i> PAYSO	oma, farm, str N STREET	aat, factory BALTO	, office , MD/F	HOME		28f. Location (Str. City or Town, 810 N. PA	Stata)			
	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the fune	edical	29a. Cartifier (Check only one)	ysician: To the bes niner: On the basis and manner s	of axamina	wiedga, daati ition and/or inv	occurred a	at tha tim	na, dete end pinion, daat	d plece, h occurr	and dua to tha ca red at tha tima, da	usa(s) and m ta and place	nannar as s , and dua t	otated. o tha causa(s)	
	To th To th comp	M	29b. Signature and title of certifier	. 1.			290	. Licans	a number		29	d. Date sign	ed (Month,	Day, Year)	
	A		1 Mayor B	ultrell	1			0.0	C.M.E		_ 1	DECEM	BER	18,1995	
	3		30. Nama and addrass of parson who	complated causa of				n C+	reet	Е	Raltimo	ro M	arul	and 21201	
	Sta		31. Daip (Hed (Month, Day, Year) 9 1995	32. Regis	trar's Signa		_ I CIII	וט_ג	Teel		OT LINO.	LC, M	arAT	and Z1ZUJ	
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		1 - FOR STATE REGISTRAR	STATE OF MARYLAN	ID / DEPA	ARTMENT OF	F HEALTH AND	MENTAL HYGIE						
			NSON		DAVII		2. DATE OF DEATH MONTH DECEMBER		5 3. T	TIME OF DEATH 7:45 A.			
pin		111-10-5502	1 ≧ M 2 □ F 75	THS.	MONTHS DAY	B HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) 06-02-19	20 M	BIRTHPLA Country)				
1, 2, 3 should	TOR	98. FACILITY NAME (If not institution, give street NORTH ARUNDEL NUR! RESIDENCE OF DECEMENT	0-212			EN BURNIE	EATH	ANNE	ARUI				
physician. burial-transit permit. Pages 1,	DIRECTOR	MARYLAND ANNE AI	RUNDEL	10c. C	GLEN	CATION BURNIE				1. INSIDE CITY LIMITS? YES 2 (X) NO			
ansit pen	FUNERAL	901 EDGERLY ROAD				21060	10g. CITIZEN OF U.S.			COUNTRY?			
or attending physician r use as the burial-trai	В	11. MARITAL STATUS 1 Never Married 2 XXMerried 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN U. FORCES? 1 X YES 2 IF YES, GIVE WAR OR DATE WW II	S. ARMED 2 NO S	If yes	DECENDENT OF HISPAN , specify Cuban, Mexica YES 2X NO Specify	en, Puello Rican, atc.) Biac			American Indian, htts, atc. WHITE			
by the hospital or attending be detached for use as the at once.	PLETED	15. DECEDENT'S EDUCAT (Specify only highest grade co Elementary/Secondary (0-12)	TION 16 mpleted) 16 N/A	(Give kind o	"S USUAL OCCUP of work done during use retired.) CARRIER	most of working	220 200 200	USINESS/INDUS					
	BE COMPL		HARLES	DAVII			ME (First, Middle, Melde		NKNOV	WN)			
y be retained sage 5 should be notified	5	198. INFORMANT'S NAME (Types/Print) MARGARET MAY DAVIDSON 199. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 901 EDGERLY ROAD, GLEN BURNIE, MD. 21060 208. METHOD OF DISPOSITION 209. PLACE AND DATE OF DISPOSITION (Name of DATE).											
leath. Page 6 may be funeral director, page xaminer must be		20a. METHOD OF DISPOSITION 1 \(\tilde{\Omega} \) Burlel 2 \(\tilde{\Omega} \) Cremetion 3 \(\tilde{\Omega} \) Remove 4 \(\tilde{\Omega} \) Donation 5 \(\tilde{\Omega} \) Other (Specify)	ol from State Cameter GLE	ACE AND DAT ry, crematory o N HAVE	e other place) EN MEMOR	IAL PARK	1965	OCATION — City GLEN BU	RNTE.	MD.			
2 2 2 0		21. SIGNATURE OF FUNERAL SERVICE LICEN	6. 500	1/00) 1 SE		JE, S.W.,	GLEN B	URNIE	HOME, E,MD.21061			
24 hours after filled in by the on, or removal he medical		23. PART I. Enter the diseases, or cor shock, or haert fellure. Lie IMMEDIATE CAUSE (Finel	it only one cause on each	i lina.		mode of dying, suc	h as cardisc or res	piratory arrest	,	Approximsta Interval Between Onset and Death			
executed within 24 in and completely fille to burial, cremation, matic event, the		disease or condition resulting in death)	Myocardial DUE TO (OR AS A CO										
e be executed sician and com- rior to burial, traumatic ev	NOI	Coronary Artery Disease 3 years Sequentially list conditions,											
ertificate be ing physician giene prior t other traus	FICAT	cause. Chief UNDERLYING CAUSE (Disease or Injury CAUSE (Disease or Injury											
0 0 4	CERTIFICATION	thet initiated events resulting in death) LAST Diabetes Mellitus 18 years											
that the od by the h and Me	MEDICAL	PART II. Other significant conditions of Peripheral Va	contributing to death but of ascular DIsea	not resulting	g in the undarl	ying cause given in		N AUTOPSY DRMED? 2X NO	CON OF I	RE AUTOPSY FINDINGS ILABLE PRIOR TO MPLETION OF CAUSE DEATH?			
has been Dept. of i		DID TOBACCO USE CONTRIE			YES NO		V 🗆			YES 2 NO			
SiCIAN: The certificate h the State d, or item	PHYSICIAN:	EXAMINER?	IOSPITAL:		OTHER:	Iome 5 - Raaldencs	8 Other (Specify)						
DING PHYSI After this co death with t marked,	ВУ РН	27. MANNER OF DEATH 1 Natural 5 Pending 2 Accident Investigation	28a. DATE OF INJURY (Month, Day, Year)		M 1 [INJURY AT WORK? YES 2 NO	28d. DESCRIBE HOW	INJURY OCCUR	ED				
L OR ATTENDING F DIRECTOR: After hours after death item 28 is mar	8	3 Suicide 8 Could not be 4 Homicide determined	28a. PLACE OF INJURY — building, etc. (Specify)	At home, farm	ı, street, factory, o	ffica	281. LOCATION (Stree City or Town, Stat		tural Route	Number,			
4 7 2 2	COMPLET	29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIA EXAMINER:	IN: To the best of my knowledg On the besis of examination an	je, death occu id/or investiga	irred at the time, o	lats and place, and due	to the cause(s) and m	anner as atated.	luse(s) and	I manner as stated.			
TO THE HOSPITE TO THE FUNERA De filed within 7 IMPORTANT:	TO BE	29b. STATE AND TITLE OF CONTINUES 30. NAME AND ADDRESS OF PERSON WHO CO	(Attendin	1 5		29c. LICENSE NUM D1416		29d. DATE SI ▶ 12/	9NED/199	gh, Day, Year)			
		Harjit Singh,	, M.D. 5410-A	Ritch	nie High	way Baltir	more, Md.	21225					



	nit. Pages 1, 2, 3 should		
aing preystolan.	ed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3		
Spilal or attern	ed for use as		
ied by the mos	ruid be detach		and the state of about and latered by address described and the considered averaging something and an analysis
may be retain	or, page 5 sho		Side of the said
eath. Page o	funeral directic		saminar and
DENTE STEEL OF	led in by the	, or removal.	a laniham
the death certificate be executed within 24 hours after death	completely fill	ial, cremation	and then a
care be execu	physician and	e prior to bur	An denisonable
e oearn cerui	the attending	Mental Hygier	diene as abb
equires mar in	in signed by t	of Health and	harres ages la
IN: The law re	ficate has bee	State Dept. c	In the man
DING PHYSICIAN: The I	After this certificate has b	death with the State Dept. of Health and Mental Hy	an advantage as
9	-	-	

	1. DEC	EGISTRAR EDENT'S NAME (First,	rine	Gatheri s. sex	ne Stanl	ley D				mber	13.19	P95	TIME OF DEATH 175H CE (State or Foreign
		2-34-1		1 M 2 F	59	YRS.	MONTHS DAY		(Month,	e 5, 1		Country)	
		CILITY NAME (If not ins		treet and number)			9b. CITY, TOV	WN DR LOCATION DE		e 5,1		Mar Y OF DEAT	yland
E C		Sinai					Bal	timore,	MG			N/A	
CTOR	RESI 10e. ST	DENCE OF DEC	10b. COUNTY	,	-	10c CIT	ry, TOWN OR LOCATION					10d, INSIDE CITY	
DIRE	1	aryland		N/A		100.011	1, 101111 011 21		timor	0			LIMITS?
		TREET AND NUMBER		11/11			Baltimore 10g. 21P CDDE 10g.						COUNTRY?
ER.	2:	245 Roge	ene D	rive, U	nit 10:	1		21209					
BY FUNERAL	11. MA 1 🗆 N	HITAL STATUS Never Married 2 Widowed 4 Divor	Married	12. WAS DECEDER	NT EVER IN U.S. AR	MED	13. WAS DECENDENT DF HISPANIC DRIGIN? (Specify Yee or No— If yes, specify Cuban, Mexican, Puerto Rican, atc.) 1 YES 2 NO Specify:					USA 4. RACE — Black, Wi Specify:	
60			EDENT'S EDU		18a. DE	CEDENT'S	USUAL OCCU	PATION	16b.	KIND OF BUS	SINESS/INDU	STRY	Black
1 15	Ele	ementary/Secondary (0	y highest grade 1-12)	College (1-4 or 5	+) Dire	Ctor	se retired.) Fa	g most of working mily Ser	vices				
COMPLE				5+	- Ar	nne A	Arundel County Greater Baltin			imore	YMCA		
	17. FAT	THER'S NAME (First, MI Robe		M. Daw	son							C+	1
1 III	19a. IN	FORMANT'S NAME (7)		. Duw		b. MAILING	ADDRESS (Str	reet and Number or Ru	ather			Stan	TeA
TO B	J	ennifer	K. D:	rayton	20	006	Tucke	rman St	. Hy	attsv	ville	. MD	2078
	20a. M	20s. METHOD OF DISPOSITION 20b. PLACE AND DATE DE DISPOSITION / DATE 20c. LOCATION — City or Town, State											
	4 🗆 0	4 © Oonetlon 5 © Other (Specify) Metro Crematory, Inc. 12/16/95 Baltimore.											
	21. SIGNATURE OF EMPERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Cremation Society of Md., I										Balti	more	, MD
	21, SIG		(Specify)		Metro	Cre	22. NAM	E AND ADDRESS OF	FACILITY				
	21, SIG	SNATURE OF SUPERAL	(Specify)		M	Cre	Cre	mation	Socie	ty of	f Md.	, In	c.
		Georg	L SERVICE LI	MacNab	b at caused the de	eath. Do	Cre 299	mation Freder	Socie ick R	ty of	f Md.	, In	C. D 2122 Approximate
	23. P	George ART I. Enter the dishock, or his	REPUICE LI	MacNab complications the List only one ca	b at caused the deuse on each line	eath. Do	Cre 299	mation Freder	Socie ick R	ty of	f Md.	, In	C . D 2122 Approximate intervel Betw
	23. P	George ART i. Enter the dishock, or he	REPUICE LI	MacNab complications the List only one ca	b at caused the de use on each line	eath. Do	Cre 299	mation Freder	Socie ick R	ty of	f Md.	, In	C . D 2122 Approximate intervel Betw
	23. P	George ART I. Enter the dishock, or his EDIATE CAUSE (Finals or condition	REPUICE LI	MacNab complications the List only one ca	b at caused the de use on each line INOMATORIAN	eath. Do	22. NAM Cre 299 not enter the	mation Freder mode of dying,	Socie ick R	ty of	f Md.	, In	C . D 2122 Approximate intervel Betw
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David Zeitung,
31. Date FILED (Month, Day, Year)

M.D. 2401

32. REGISTRAR'S SIGNATURE

Belvedere Ave. Balto., MD 21215-5271

Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible.

State of Maryland / Department of Health and Mental Hygiene 95 38208

					(Certifica	te of	Death		R	eg. No.			
	Dharata		1. Decedent's Name (First, Middla, Last)	6					2. Data of Deal Month		Yaar	3. Time of Death	A
	Physic /Medi		LILLIAN	M. DA	VIS						16 19		10:26	1,44
1	Exami		4a. Facility Name (If not institution, giva							ocation of Death	4c. County			
1			4 BROOKING CT. AI			M. Harde	- d Maa		N/A			IMORE		
	Funeral Director		5. Social Security Number 6. Sa 212-26-4924 Usual Rasidanca of Decedant	7. Aga (/n	yrs. last birth	Months	Days		Min.	8. Date of Birth (Month, Day	Year)	9. Birthpl Coun OCT	laca (Stata or Foraig try) 01, 1924	n
	ylend		10a. Stata 10b. County	100	. City, Town	or Location				-		10	0d. Inside City Limits	5
	Mar Maria	ctor	MD BALTIMOR	RE				N/A					1 ☐ Yes 2 No)
	death with the Maryland	al Director	4 BROOKING CT. AP1	201			2109	93		10g. Citizen of What Country? USA			fry?	
21215-0020	ours after dea al', or items Examiner m	by Funeral	11. Maritai Status 1 Navar Married Married 3 Widowed 4 Divorced	12. Was Decedent Ever Armed Forces? 1 Yas 2 No If Yes, Giva Year or Dates:	In U,S.	13. Was Dece If Yas, spe 1 Yes	cify Cul	oan, Maxicar	n, Puarto	ecify Yes or No- Rican, atc.)	ecify Yes or No- Rican, atc.) 14. Race - A Black, W Specify:			
5-0	Stould be filed within 72 hours after des and Mental Hygiene. Is marked other than "natural", or flems summitic event, the Mental exemples.		15. Decedent's Edu (Specify only highast grad	de completed) (Give kind of w			ork dona	i <i>duri</i> na mos	t of work	ina	16b. Kind of Bu	usinass/inc	lustry	
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ary	1 to, Mally idilia, 8 1 and 2 should be filed 1 Health and Mental Hyg tem 27 is marked other other traumatic event,		19a. Informant's Name/Ralationship (T)	rpe, Print)	19b. 1	Malling Addras	s (Stree	t and Numbe	er or Run	al Routa Number	, City or Town,	Stata, Zip	Code)	
			HAROLD F. DAV	AVIS 4 BROOKING CT. AF		PT 2	01 BALT	TIMORE !	MARYL	AND 21093	3			
Baltimore,	00		20a. Mathod of Disposition 1 Buriai 2 □ Cramation 3 □ F 4 □ Donation 5 □ Othar (Specify)	Ramoval from Stata	b. Place of U comatary PARKV	Disposition (Na , cramatory or VOOD	ma of other place.			Data 12/19	City or To			
Balt	permit. Peg Department Important: It any Injury o		21. Signature of Funeral Sarvice Licans	00-		HARTL	EY M		FUN	ERAL HON				
	-		23a. Part1. Enter tha disease, or compi	ications that caused the	death. Do no	7527 ot antar tha mo	HA RE	Ing, such as	OAD cardiac	BALT IMOF or respiratory arm	ast,	21234	Approximata	
la D	hysician /Medicai		shock, or heart failura. List only o	C (OPD)							Interval Between Onsat and Death + 204r	S.
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o,	e execute ian and uriel-trans	Examiner	Sequantially list conditions, if any, leading to immediata causa. Entar Undarlying Causa (Disease or Injury	Dua	to (or as a co	onsequance of)	*							
x 68760,	deeth certificate be executed e attending physician and of for use es the buriel-transit	Medical	that initiated events resulting in death) Last	Dua	Dua to (or as a consequence of):									
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P.O.	thet the deeth cert ed by the ettendin detached for use	Physician/	Part II. Other significant conditions con	ntributing to death but no	resulting in t	tha undartying	causa g	ivan In Part I		. /			the cause of death	
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Records,	been been shoul	Completed b								24a. Was a perform	n autopsy med?	ava cor	ara autopsy findings allable prior to mplation of causa death?	
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Vitai	yalclan: The	Be	25. Was case referred to medical axaminar?					26. Piaca	of Deat	h (Check only on	na.)	1		
of V	S 00 00	2	1 Yas 2 No		2 ER/Outp		UA		-	ma 5 Raside		ar (Specify	1)	
Division of	After After fune	ation:	27. Mannar of Death Dantural 5 Panding Accident invastigation	28a. Data of Injury (Month, Day Yes	28b. Tir Inj	ma of ury M	28c. Inju Wo 1	ıryat ork?]Yas 2□		28d. Dascribe ho	ow Injury occur	red		
Divis	tal or Attences effectives at Director:	Certification:	3 ☐ Suicida 6 ☐ Could not be datarmined	28a. Place of Injury - building, atc. (Sp	At homa, fam pecify)	n, street, factor	y, office			28f. Location (Si City or Town		er or Rura	l Route Number,	
	To the Hospital within 24 hours e To the Funeral Completely filled	edicai	29a. Cartifiar (Check only one) Certifying Physical Examination (Check only one)	elcian: To the best of my ner: On the basis of axer and manner stated.	knowledga, onlination and/	daath occurred or invastigation	at tha t n, In my	ima, data an opini <i>on</i> , daa	d piace, th occurr	and dua to tha cred at tha tima, d	ausa(s) and me ata and place,	innar as st and dua to	ated. tha causa(s)	
	Tot with Tot	2	29b. Signature of this of certifiar	P. Cost	to			se number 950	3		9d. Data signe スール			
			30. Nama and addrass of person who as EDWARD P	emplated causa of death	(Item 23a) (T	ype, Print)	10	Ger	RD	Ave214	TIMON	1Um M	5 21093	
	Sta Registr	_	31. Date DE 10011, 191995	32 Begis var's S	Pature 1									9

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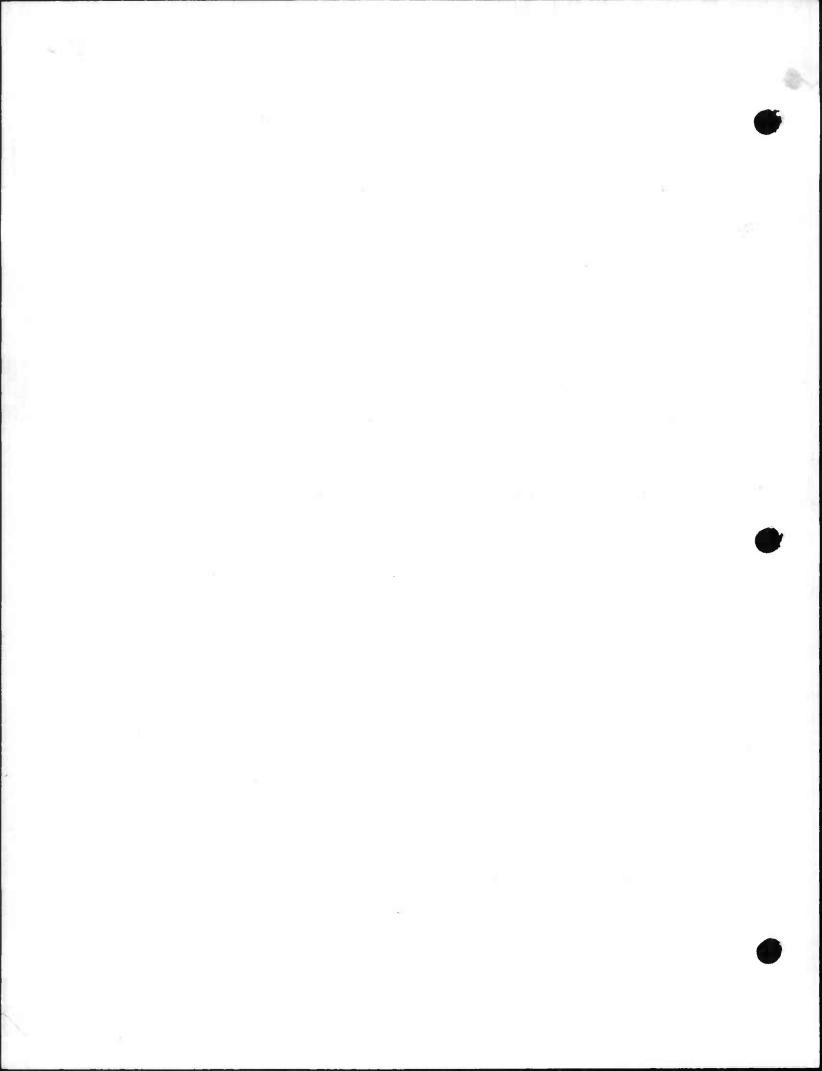


BALTIMORE, MARYLAND 21215-0020	Thours after death. Page 6 may be retained by the hospital or attending physician.	is certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	the medical examiner must be notified at once.
DIVISION OF VITAL RECORDS, P.O. BOX 68760	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within-es hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funer be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, P.O. BOX 68760

1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAN				VL	11111	ICAL		DEA	ın		REG. NO			
	1, DECEDENT'S NAME (First, Mi	iddle, Last)							•		2. DAT	OF DEATH	AY	YEAR	3. TIME OF DEATN
	Edith Dy	er													12:00pm
	4. SOCIAL SECURITY NUMBER	1	5. SEX	6. AGE	(In yrs. lest b	oirthday)	IF UNDER		IF UNDE		7. DATE	OF BIRTH		8. BIRTNP	LACE (State or Foreign
	215 50 7438		1 🗌 M 2 💢 F	94	1	YRS.	MONTHS	DAYS	HOURS	MIN.	Aug	th, Day Year)	901	Mo .	
	9a. FACILITY NAME (If not institu	ution, give s	treet and number)				9b. CITY	. TOWN	OR LOCATI	ION OF DI				NTY OF DE	ATM
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DIRECTOR	RESIDENCE OF DECE														
JË	10a. STATE 10	Db. COUNTY					Y, TOWN								10d. INSIDE CITY
<u>=</u>	Md.		Carroll				Syke	SVI	lle						LIMITS?
4	10e. STREET AND NUMBER	-						10	f. ZIP COD	E			10g. CITI		IAT COUNTRY?
FUNERAL	7200 Third	Ave.						2	1784				U.S	S. A.	
	11. MARITAL STATUS		12. WAS DECEDEN	T EVER II	N U.S. ARMI	ED	13.	WAS DEC	CENDENT (OF HISPAI	NC ORIG	N? (Specify Ver	or No	14 BACE	- American Indian.
	1 Never Married 2 X Ma		FORCES? 1					If yes, sp	ecify Cubi	ecify Cuban, Maxican, Puarto Rican, atc.) Black, White, etc.				White, etc.	
B√	3 Widowed 4 Divorce	d						1 1 163	2 2,40	apacii	γ.			Specify	
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그리	High School		-4	'		Tea	cher						Schoo	1	
ō	17. FATNER'S NAME (First, Middle, Last) 18. MOTNER'S NAME (First, Middle, Maiden Surname)														
	Ernest Mil	ler							-			1 Smit	,		
BE	19a. INFORMANT'S NAME (Type				195	MAILING	ADDRES	S (Streat				ber, City or Tow		Code	
2		ver													D.C. 20008
	20a. METHOD OF DISPOSITION									Ly LV					
	1X Burial 2 Cremation	3 🗌 Reme	oval from Stata	сеп	netary, creme	story or of	har place!					20c. LO			
	4 Donation 5 Other (Sp 21. SIGNATURE OF FUNERAL S		ENSEE	Ar	ling	ton			Ceme 1			19/95	Arlir	igton	, Va.
- 8	. ()	4 1	11 -11				22.	NAME A	ND ADDRE			t Fune	ral F	lome	
	HOME T	(U.)	Hount.				P	O B	ov 10						/1
	23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interval Batuses.														
	snock/ or heart fellure. List only one cause on each line.														
	disease or condition previous										lodays				
			dem							12 4	13.	01 10 1	ď		10.00
CERTIFICATION	Sequentially list condition	10,	DUE TO	(OR AS A	CONSEQU	ENCE OF	٦٠		7		. — 1	10			10712
AT.	if sny, leading to immediate cause. Enter UNDERLYING					-1723	,								į
윤	CAUSE (Disesse or injury that initiated events	1	DUE TO	(OR AS A	CONSEQU	ENCE OF):								
E	resulting in death) LAST														
E E			d	-											1
	PART II. Other significant	condition	s contributing to	deeth b	ut not res	sulting i	n the ur	nderlyln	g cause :	given in	Part I.	24a. WAS AN			VERE AUTOPSY FINDINGS
EDICAL												PERFOR			WAILABLE PRIOR TO COMPLETION OF CAUSE
	8											. N 1E3 2			OF DEATH?
. M	DID TOBACCO USE	CONTI	RIBUTE TO CA	USF O	F DEATI	H YF	SII	NO F	TIMO	ERTAI	<u> П</u>			1	☐ YES 2 NO
PHYSICIAN:	25. WAS CASE REFERRED TO M				26. PLACE				. 5140		· <u> </u>				
Sic	EXAMINER?		HOSPITAL:	FB/Oute	nationt 3	DOA!	OTHE					- 10			
ΙŽ	27. MANNER OF DEATH		26s. DATE OF		_	28b. TIMI		26c. INJ	URY AT	sudenca		SCRIBE HOW I	A ILIBA UCA	TIPED	
	1 Natural 5 Pen		(Month, D	ny. Year)		INJ	URY	WO	PRK?	3 NO	200. DE	JOHNE HOW I	10011 000	JONED	
B	2 Sutelde	estigation	26a. PLACE O	F INJURY	_ At home	term e	treet test				201 1 0	CATION (Street a			
B	_ 0 _ 000	uld not be ermined	building,	atc. (Spec	cify)	o, (eriii, a	arews, tace	ory, orne				or Town, State)	ind Number	or Hurel Ho	ne Number,
COMPLETED	29e. CERTIFIER	-				-						-			
AP.	(Check only		CIAN: To the best of												
ō	2 MEDICAL	LEXAMINE	R: On the basis of a	aminatio	n and/or Inv	eatigation	n, In my o	pinion, d	leath occur	red at the	time, det	and place, an	d dua to th	e cause(a)	and menner ee stated.
	29b. SIGNATURE AND TITLE OF	-							29c, LICI	ENSE NUN	/BER		29d, DATI	E SIGNED (Nonth, Day, Year)
) BE	in	7. U	m MD						b:	344	06			2/14	195
유	30. NAME AND ADDRESS OF PE	ERSON WHO	COMPLETED CAUS	E OF DE	ATH (ITEM 2	27) (Type,	Print)							1	1
	Richmond	P.	Allan	ill	045	Li	ber	+-	Rd.	, F	ld	いっかい	C/ 1	MD	21784
	31. DATE FILED (Month, Day, Year	r)	32. REGISTRA							-			1	-	-1.01
	DEC 1 6	1995	(1) Ma			20									
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	S stiff year	ath with:	marked,
DINGRESS	After this 8	death with	s marked,
ENDINGRADS	R: After this 8	ter death with i	is marked,
TTENDING MANS	CTOR: After this c	after death with I	28 is marked,
R ATTENDING MATE	RECTOR: After this c	urs after death with I	m 28 is marked,
OR ATTENDING WITH	DIRECTOR: After this o	hours after death with	item 28 is nranked,
TAL OR ATTENDING MAN	AL DIRECTOR: After the c	72 hours after death with 1	If item 28 is marked,
PITAL OR ATTENDING	ERAL DIRECTOR: After the c	in 72 hours after death with 1	T: If item 28 is nranked,
IOSPITAL OR ATTENDING	UNERAL DIRECTOR: After the C	rithin 72 hours after death with 1	ANT: If item 28 is marked,
HOSPITAL OR ATTENDING	FUNERAL DIRECTOR: After the C	within 72 hours after death with	STANT: If item 28 is nranked,
'HE HOSPITAL OR ATTENDIN	THE FUNERAL DIRECTOR: After the C	led within 72 hours after death with 1	ORTANT: If item 28 is marked,
TO THE HOSPITAL OR ATTENDING TO THE CONTROL OF THE LOSPITAL OR ATTENDING TO WITHING	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely	be filed within 72 hours after deall with the State Dept. of Health and Mental Hygiene prior to burial, cremati	IMPORTANT: If item 28 is marked, or item 23 shows any Injury, or other traumatic event, t

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Lest) MARY EMELINE EVLER 2. DATE OF DEATH 3. TIME OF DEATH EVELINE EVLER, STR. Dec 16 1995 8:40 pm 4. SOCIAL SECURITY NUMBER 5. SEX 8. BIRTHPLACE (State or Foreign Country) 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year) 1 M 2 TF 216-66-9945 87 14 Dec. Pennsylvinia 9s. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH Saint Joseph Medical Center DIRECTOR Towson, Maryland Baltimore RESIDENCE OF DECEDENT 10a. STATE 10h COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Baltimore Baltimore 1 YES 2 NO 10a, STREET AND NUMBER FUNERAL 10g. CITIZEN OF WHAT COUNTRY? 6401 N. Charles Street 21212 U.S.A. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. BACE — American Indian, Black, White, atc. 1X Never Married 2 Married If yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 TYES 2 NO Specify: Specify: BY 3 Widowed 4 Divorced White COMPLETED 16e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only high Elementary/Secondary (0-12) College (1-4 or 5+) Educator/Religious 4 years Religious once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) John William Eyler F Elizabeth Wise BE notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Yown, State, Zip Code) 5 Sr. Bernice Feilinger, S.S.N.D. 6401 N. Charles St. Baltimore, Maryland 21212 pe 20e. METHOD OF DISPOSITION
1-03 Burlel 2 Cremetion 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State must Villa Maria Cemetery 4 Donation 5 Other (Specify) _ Glen Arm, Maryland examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY
Mitchell-Wiedefeld Home Severe Ferrer 6500 York Rd. Baltimore, Mary
23. PART I. Enter the diseases or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 6500 York Rd. Baltimore, Maryland 21212 medical Approximate shock, or heart failure. List only one ceuse on each line interval Between Onset and Death IMMEDIATE CAUSE (Finel the disease or condition 2 DAYS **PNEUMONIA** resulting in death) event, DUE TO (OR AS A CONSEQUENCE OF): traumatic CERTIFICATION Sequentially list conditions. DUE TO (OR AS A CONSEQUENCE OF): if sny, lesding to immediate cause. Enter UNDERLYING CAUSE (Disesse or injury other DUE TO (OR AS A CONSEQUENCE OF): that initisted events resulting in deeth) LAST 0 Injury, o PART II. Other significent conditions contributing to deeth but not resulting in the underlying ceuse given in Part I. 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS MEDICAL AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? shows any 1 YES 2 NO 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES IN NO IN UNCERTAIN IN PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL 28. PLACE DF DEATH (Check only one) Hem OTHER: 1 TYES 2 O Inpatient 2 - ER/Outpatient 3 - DOA 4 - Nursing Home 5 - Residence 6 - Other (Specify) ö 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME DF INJURY 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED rearked. 1 Natural 1 YES 2 NO В Investigation Accident 28a. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify) 28t. LOCATION (Street and Number or Rural Route Number, City or Town, State) 60 3 Suicide 8 Could not be COMPLETED 200 4 Homicide item 29a. CERTIFIER (Chack only 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as attend. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and menner as stated. 29b. SIGNATURE, AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE 116/95 usrera. D 46673 5

1995

31. DATE FILEDEC 1"9"

SS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

Jew dudyor Karlell

ANTHONY H. GUARINO, M.D. ST. JOSEPH MEDICAL CENTER, TOWSON, MD. 21204

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: It item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. DIVISION OF VITAL RECORDS, P.O. BOX 68760

FOR 1 - STATE

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

REGISTRAR		CERTIF	ICATE OF I	DEATH	REG. N	O.					
1. DECEDENT'S NAME (First, Middle, Lest) FRANCES		EMG	E		2. DATE OF OEATH	°¥995	3. TIME OF CEATH 3:50 am				
4. SOCIAL SECURITY NUMBER	1 🗆 M 2 🔀 F	AGE (In yrs. lest birthday) YRS.		IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year)		BIRTHPLACE (State or Foreign Country) ARY LAND				
9a. FACILITY NAME (If not inatitution, give Saint Joseph Medio			9b. CITY, TOWN OR TOWS	on, Maryle		9c. COUNTY OF DEATH Baltimore					
10a. STATE 10b. COUNT	-	10c. CIT	ARKVI	NC 211			10d. INSIDE CITY LIMITS? 1 YES 2 NO				
10. STREET AND NUMBER 830 Glan 11. MARITAL STATUS 1 Never Merried 2 M Merried	ROAD			21931	,	U.	S. A.				
3 Widowed 4 Divorced	12. WAS OECEDENT EV FORCES? 1 I	YES 2 NO	If yes, spec	NOENT OF HISPAN lify Cuben, Maxica (E), NO Specify	es or No— 14.	RACE — American Indian, Black, White, etc. Specify:					
(Specify only highest grade	15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) College (1-4 or 5+) College (1-4 or 5+) College (1-4 or 5+) College (1-4 or 5+) College (1-4 or 5+) College (1-4 or 5+) College (1-4 or 5+)										
17. FATHER'S NAME (First, Middle, Last) TH SOORS	Lucar			18. MOTHER'S NAI	ME (First, Middle, Maide		LAIOLK TO				
Graffe S. Sc	765		4 1	Number or Rural F	ARKV, LL	wn, State, Zip Co	RYLAND RYLAND				
20a. METHOD OF DISPOSITION Burial 2 Cremation 3 Rem Donation 8 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LU		20b. PLACE AND DATE (compatery, crematory or of ARKWO)	her plech S	VAZI	12:14 P	OCATION - CITY	S MARYLAND				
1 Tools An	FLOR 45 MOROL SAUGHO HAUFORD GODO - HUKNITTE										
23. PART I. Enter the diseases, or shock, or heart failure. IMMEDIATE CAUSE (Finel disease or condition resulting in death)	ACUTE MY	OCARDIAL	INFARCTIO		n as cardled or rea	piratory arrest	Approximate Interval Between Onset and Death 2 HOUR				
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events										
PART II. Other algorificent condition HYPOKALEMIA HYPERTENSION	d	th but not resulting I	n the underlying (cause given in	Part I. 24a. WAS A PERFO	RMED?	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?				
DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL		26. PLACE OF DEAT		UNCERTAIN	10		1 TYES 2/5, NO				
EXAMINER? 1 YES 2 NO 27. MANNER OF OEATH 1 Netural 5 Pending	HOSPITAL: 1 Inpatient 2 ER/ 26e. DATE OF INJU (Month, Day, Ye	JRY 26b. TIM	URY WORK	TY AT	8 Other (Specify) 28d. DESCRIBE NOW	INJURY OCCUR	ED				
2 Accident Investigation 3 Suicide 6 Could not be	2 Accident Investigation 3 Suicide 6 Could not be 28e. PLACE OF INJURY — At home, term, street, factory, office 28t. LOCATION (Street and Number or Rural Route building, etc. (Specify)										
	29a. CERTIFIER (Check only 1 CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as eteted.										
TURE AND TITLE OF CHILING	mecales		2	9c. LICENSE NUM D 32338		29d. DATE 81	GNEO (Month, Day, Year)				
RONALD SCHECHT	ER,MD 6565			EET; SUIT	E # 615 B#						



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TO BE COMPLETED BY FUNERAL DIRECTOR

DAL IMORE, MANTLAND	hours after death. Page 6 may be retained by the hosp	led in by the funeral director, page 5 should be detache	i, or removal.	medical examiner must be notified at once.	
DIVISION OF VITAL MECONDS, T.O. BOX 500 C	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospi	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to bunal, cremation, or removal.	IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1 - FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.									
1. DECEDENT'S NAME (First, Middle, Last)	Henry Robso				MONTH	OF DEATH	1. 19	EAR	ME OF DEATH 4:05PM M
4. SOCIAL SECURITY NUMBER 5.		yrs. lest birthday) IF	UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE O	OF BIRTH , Day, Year)	8.	BIRTHPLAC	E (State or Foreign
216-09-2339	Ø M 2 □ F 75	YRS.	NTHS DAYS	HOURS MIN.		6.192		Mary)	land
9a. FACILITY NAME (If not institution, give street	and number)	91	CITY, TOWN O	R LOCATION OF DE			9c. COUNTY		
153 North Lakewood	d Avenue		Balti	more Ci	tu	- 1	N.	/A	
RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY			OWN OR LOCAT	ALI .					
Maryland	N/A	100. 0111, 1			. 0:4				INSIDE CITY LIMITS?
10e. STREET AND NUMBER	IV/A			Baltimore City			10a CITIZEN	t X YES 2 1 NO N OF WHAT COUNTRY?	
153 North Lakewood	Auguna		101	21224 United					
	. WAS DECEOENT EVER IN L	.S. ARMED	13. WAS DEC	ENDENT OF HISPAI		? (Specify Yes o	-		merican indian.
1 Never Married 2XX Married	FORCES? 1 YES	2 NO	If yes, spe	city Cuban, Mexica 2 🖫 NO Specifi	in, Puerlo R		1.0	Black, Whi	ita, atc.
3 Widowed 4 Divorced		WWII	1 123	z Of the specif	у.			Specify	White
ts. DECEDENT'S EDUCATO (Specify only highest grade con	ON 1	6a. DECEDENT'S US			16b.	KIND OF BUSH	NESS/INDUS	TRY	
Elementary/Secondary (0-12)	College (1-4 or 5 +)	fife. Do NOT use n	etired.)	it or worning	4				
12 Years		Yard	Clerk			Rail	Road		
17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NA	ME (First, A	Aiddle, Maiden Si	umame)		
Henry E. Eberling					Tierne				
tion. INFORMANT'S NAME (Type/Print) Phyllis May Ebe	rling	195. MAILING AD	rth Lak	ewood Av	Poute Numb	Baltimo	State Zip Co	MD 2	1224
20a. METHOD OF DISPOSITION 1 Burial 2 Cremetion 3 Removal	20b. P	LACE AND DATE OF I	-11		DATE		ATION — City		
4 Donation 5 Other (Specify)	Ga	rrison Fi	orest V	.A. Cem. 1	2/14	195 Ou	vings	Mill	s. MD
21. SIGNATURE OF FUNERAL SERVICE LICENS	1			Ruck Fur		Hama	al Du	dalh	Tua
+ Yaul L Harts	rhile			Wise Ave					
23, PART I. Enter the diseases, or com- shock, or heart failure. List IMMEDIATE CAUSE (Final disease or condition resulting in death)	DUE TO (OR AS A C	h line.					ntory arrest		Approximate Interval Between Onset and Death
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (OR AS A C								
PART II. Other significant conditions of	ontributing to death but		the underlying	cause given in	Part I.	24a. WAS AN A PERFORM 1 YES 2	EO?	AWAJ	E AUTOPSY FINDINGS LABLE PRIOR TO IPLETION OF CAUSE
	,						A		YES 2 NO
DID TOBACCO USE CONTRIB	SUTE TO CAUSE OF	DEATH YES	W NO [UNCERTAI	N 🗆				
25. WAS CASE REFERRED TO MEDICAL	20	. PLACE OF DEATH							
	OSPITAL:		THER:	e 5 [YRaaldenca	6 Other	r (Specify)			
27. MANNER OF DEATH	26a. DATE OF INJURY	26b. TIME D	F 28c. INJ	URY AT		CRIBE HOW IN	JURY OCCUP	RED	
1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	INJUR		RK? 'ES 2 NO					
3 Suicide 8 Could not be 4 Homicide determined	28e. PLACE OF INJURY - building, atc. (Specify	At home, farm, atre	et, factory, office		26f. LOC	ATION (Street an or Town, Statu)	d Number or	Rural Route	Number,
29a. CERTIFIER A VOCESTIEVING BUYERS	No To the best of the control of	des destheres							
(Check only one) 1 XXCERTIFYING PHYSICIA (Check only one) 2 MEDICAL EXAMINER: (On the basis of axamination							ausola) and	menner as stated
			y opinion, u						
296, SIGNATURE AND TITLE OF CERTIFIER	RO	. /		29c. LICENSE NU	MBER . "	,	29d. DATE S	IGNED (Mon	oth, Day, Year)
30. NAME AND ADDRESS OF PERSON WHO C	OMPLETED CAUSE OF DEAT	wx	7-10	1145	54.	>	12/	12/	15
Bobert Bo	odsky (300 M	int)	Ife 5	7	13011	- ms) 2	1287
31. DELLI 91995 ALL	32 REGISTRAR'S GNA	URE							

TO THE HOSPITAL DR ATTENDING PHYSICIANS: The law requires that the death certificate be executed withing an office of the four sides 6 may be retained by the hospital or attending physician. To THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit, Pages 1, 2, 3 should	be filed within 72 hours after death with the State Dept. of Health and Mental Hyghere prior to burfal, cremation, or removal.	IMFORTANT: It item 28 is marked, of item 2.5 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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				95	38213					
	1 - FOR STATE OF MARYLAND / DEPA CERTIF	RTMENT OF HEALTH AND I	MENTAL HYGIENE REG. NO.							
	1. DECEDENT'S NAME (First, Middle, Lest)		2. DATE OF DEATH	1:	3. TIME OF DEATH					
	ISABELLA. D. ELKINS		DEC 116	R 95	7.05 Pm					
	4. SOCIAL SECURITY HUMBER 5. SEX 6. AGE (In yrs last birthday)		7. DATE OF BIRTH (Month, Day, Year)	8. BIRTHPI Country)	LACE (State or Foreign					
	214-24-7438 1 M 2 X F 88 YRS.	MONTHS DAYS HOURS MIN.	AUG. 19, 19		TH CAROLINA					
_	9a. FACILITY HAME (If not institution, give street and number)	9b. CITY, TOWN OR LOCATION OF DE		c. COUHTY OF DEA						
2	NORTHWEST MEDICAL CENTER	BALTIMORE C	ITY	N/A						
E E		HTY, TOWN OR LOCATION		1	IOd. IHSIDE CITY					
DIRECTOR	MARYLAND N/A	BALTIMORE C	ITY		LIMITS?					
A	10e. STREET AND HUMBER	10f. ZIP CODE	10	0g. CITIZEN OF WH	IAT COUNTRY?					
	2531 LOYOLA NORTHWAY	2121	5	USA.						
FUNERAL	11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO	13. WAS DECEMBENT OF HISPAN If yes, specify Cuben, Mexica		No→ 14. RACE -	- American Indian, White, etc.					
BY 1	1 Never Merried 2 Merried IF YES, GIVE WAR OR DATES 3 X Widowed 4 Divorced	1 YES 2X HO Specifi		Specify.						
	15. DECEDENT'S EDUCATION 16s. DECEDENT	'S USUAL OCCUPATION	16b. KIND OF BUSINE	BLAC	CK					
COMPLETED	(Specify only highest grade completed) (Give kind o	of work done during most of working use retired.)	166. KIND OF BUSINE	ESS/INDUSTRY						
PL	Elementary/Secondary (0-12) College (1-4 or 5+)	SEAMSTRESS	BOUTIO	OHE						
NO.	17. FATHER'S HAME (First, Middle, Lest)		ME (First, Middle, Maiden Sur							
	NORMAN REIVES	ANNA		MINTER						
BE	19e. IHFORMAHT'S HAME (Type/Print) 19b. MAILIF	HG ADDRESS (Street and Number or Rural	Route Number, City or Town, S	State, Zip Code)						
2	GLORIA DOWNS 2531	LOYOLA NORTHWAY	, BALTIMORE,	, MARYLAN	ND 21215					
	20s. METHOD OF DISPOSITIOH 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION — City or Town, Statu									
	4 Donation 6 Forting (Specify) ARBUTUS CEMETERY 12-16-95 ARBUTUS, MARYLAND									
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE	JOSEPH H. BRO	WN JR. FUNER	RAL HOME	. P. A.					
	The state of the s	1913 W. BALTI								
	23. PART I. Enter the diseases, or complications that caused the deeth. Do	not enter the mode of dying, suc	h ss cerdiec or respirat	ory srreat,	Approximate					
	ahock, or heert fellure. List only one cause on each line. IMMEDIATE CAUSE (Final				Onset and Death					
Н	Manager or an addition	PNEUMONIA			3WEEK					
- 0	DUE TO (OR AS A CONSEQUENCE	PHEUMONIA			3 4 6 6 1					
Z	Sequentielly list conditions, Many heating to immediate b. DUE TO (OR AS A CONSCOUENCE	EDEMA			3 WEEKS					
CERTIFICATION	il ally, readilig to illiliadiete	OF):								
2	CAUSE. (Disease or Injury CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE				3 WEEKS					
Ē	that initieted events resulting in deeth) LAST	OF):								
ij	d.				1					
	PART II. Other algnificent conditions contributing to death but not resulting				WERE AUTOPSY FIHDINGS AVAILABLE PRIOR TO					
2	DIABETES MELLITUS 2 CE	REBROVAS CULA!	1 YES 2 ()	Vana (COMPLETION OF CAUSE OF DEATH?					
MEDICAL	ACCIDENT.		_ ′	1	T YES 2 HO					
	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH	YES NO UNCERTAIL	NX							
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DE HOSPITAL:	EATH (Check only one)								
YS.	1 U YES 2 NO 1'S Inpatient 2 ER/Outpetient 3 DOA	OTHER: 4 Hursing Home 5 Residence	6 Other (Specify)							
H	(Month, Day, Year)	TIME OF 28c, INJURY AT WORK?	28d. DESCRIBE HOW IHJU	URY OCCURED						
ВХ	1 O Haturel 5 Pending 2 Accident Investigation	M 1 YES 2 HO								
	3 Suicide 8 Could not be datermined 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 28f. LOCATIOH (Street and Number or Rural Route No. City or Town, State)									
COMPLETED	29s. CERTIFIER									
MPL	(Check only 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occu									
00	Z MEDICAL EXAMINER: On the basis of exemination and/or investigation	ition, in my opinion, death occured at the	time, date and place, and d	Jue to the cause(a)	and manner as stated.					
BE (29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICEHSE NUI		9d. DATE SIGNED	11					
10	TO I WILL IN TO		410	DEC	1104 95					
	30. HAME AND APPRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Ty	rpe, Print)			and the second					

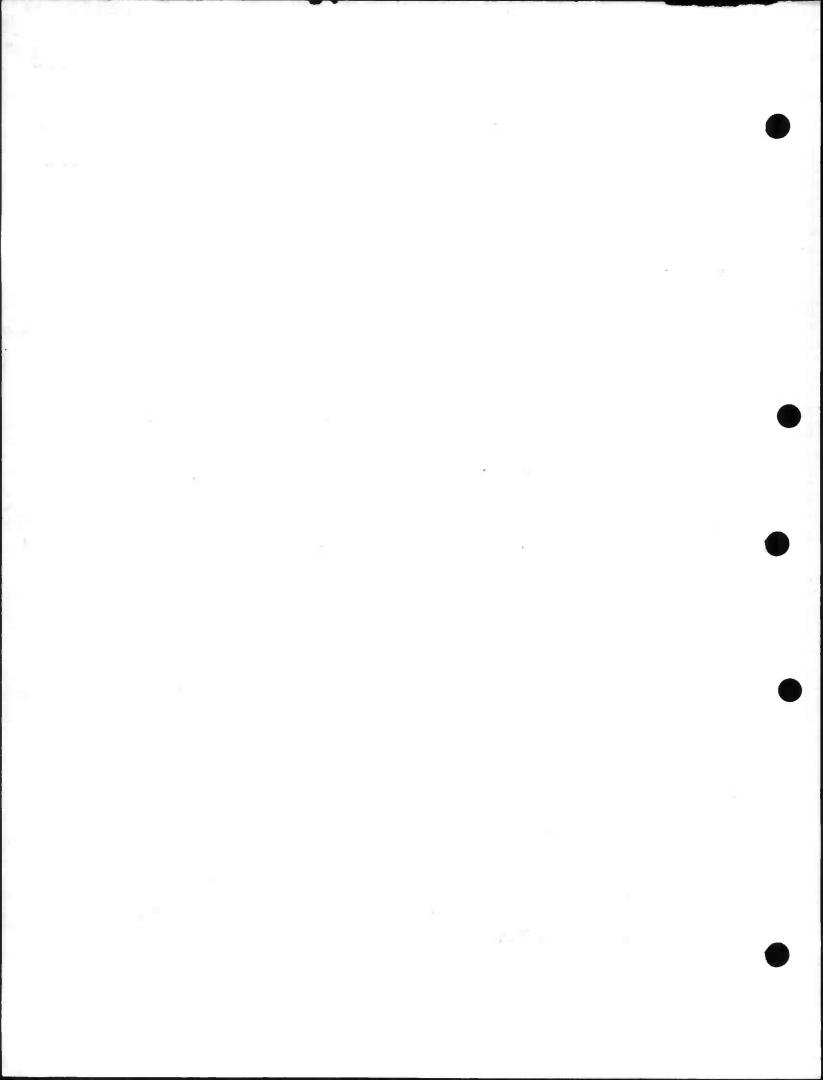
RANDAUSTOWN

HOSPITAL CENTER

2. REGISTRAT SEIGNATURE



DHMH-16 Rev 1/89



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FOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

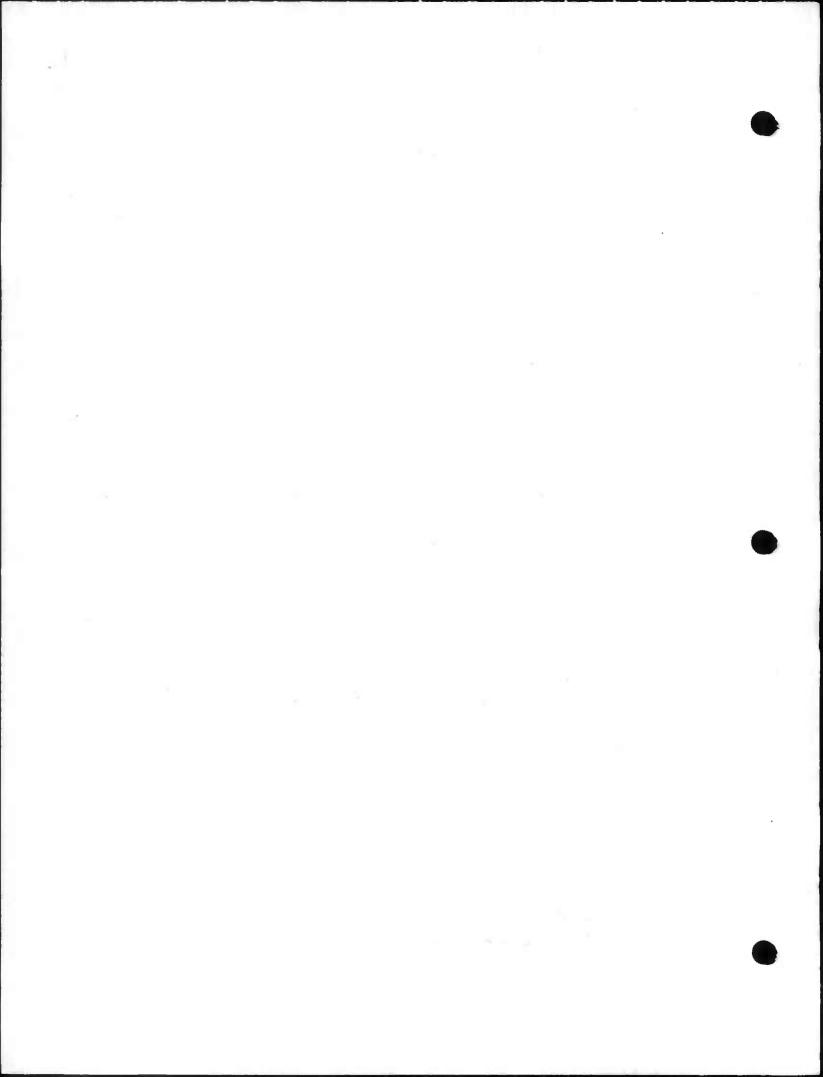
	REGISTRAR			ENTIF	ICALE	UF	DEATH		REG. NO.			
	1. DECEDENT'S NAME (First, Middle, Last) Thyra Waltham	Fische	r					1.	Dec. 17,	190	95	3. TIME OF OEATH 9:10 DM
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. I	ast birthday)	IF UNDER 1	YEAR	IF UNDER 24 HR	_	7. DATE OF BIRTH			IPLACE (State or Foreign
	216-46-5571	1 □ M 2 🏹 F	83	YRS.		DAYS	HOURS MI		(Month, Day, Year) March 24,	1912	Count	yland
	9a. FACILITY NAME (If not institution, give st	treet and number)			9b. CITY, TOWN OR LOCATION OF DEATH					9c. COUNTY OF DEATH		
DIRECTOR	Edenwald				Towson					Baltimore		
입	10a. STATE 10b. COUNTY	1		10c. CIT	Y, TOWN OF	LOCAT	ION					10d. INSIDE CITY
		imore		To	wson					1 X YES 2 NO		
4	10e. STREET AND NUMBER			101. ZIP CODE				10g. CITIZEN OF WHAT COUNTRY?				
5	800 Southerly Road	d		21286					U.S.A.			
FUNERAL	11. MARITAL STATUS	12. WAS DECEDEN		N U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify 12 NO If yes, specify Cuban, Mexican, Puerto Rican, stc.)					ORIGIN? (Specify Yes	or No-	14. RACI	E — American Indien, k, White, etc.
BY F	1 Never Married 2 Married 3 Widowed 4 Divorced	IF YES, GIVE W		ĮNO	1	YES	2 X NO Sc	pecify:	Puento Hican, atc.)		Spec	
COMPLETED	15. DECEDENT'S EDUC (Specify only highest grade	CATION completed)		DECEDENT'S	work done di	CUPATIO	ON st of working		18b. KIND OF BUS	SINESS/IN	DUSTRY	
91	Elementary/Secondary (0-12)	Elementary/Secondary (0-12) College (1-4 or 5+) 5+ years			se retired.)							
M M		Se	conda	ry Te	ach	er		High Sc	hoo1	Edu	cation	
ᅙ	17. FATHER'S NAME (First, Middle, Last)						18. MOTHER'S	S NAMI	E (First, Middle, Maiden	Sumame)		
Leo Waltham Mary Grothau							thaus					
	19s. INFORMANT'S NAME (Type/Print)		-	96. MAILING	AOORESS	(Street m	nd Number or Ri	ural Ro	ute Number, City or Tow	n, Stete, Zij	p Code)	20 PT T
임	Mary Ellen Fische	er		32 Wh	ite S	tre	et Saı	rat	oga Sprin	gs.	N.Y.	12866
	200 METHOD OF DISPOSITION		20b. PLAC	E AND DATE	OF OISPOSI	TION /Na	me of		DATE 20c. LO	CATION -	City or To	own, State
	1 X Burial 2 Cremation 3 Remo	oval from State	Drui	I Rid	ther place)	met	erv De	ec.	20 Pik	esvi	11e.	Maryland
	21. SIGNATURE OF FUNDRAL SERVICE LIC	AFFISEE A	0 (1	22. N	AME A	ID ADDRESS OF	F FACI	feld Home	_		1212 y Lund
	heus	beech	Sue	+					ield Home Baltimore			12
	23. PART I. Enter the disesses, or o	omplications that	caused the	death. Do			and the second second	_		_		Approximate
	ahock, or heart fellure.	List only one csu	ae on sach lie	ne.	1							Interval Between Onset and Daeth
	IMMEDIATE CAUSE (Finsi disease or condition											
- 1	reaulting in death)	a	IOR AS A CONS	EOUENCE O	F: .		msu	m	wency			19
_		0		0	011	1	1 1	΄,	to De	do .A	to	244
<u></u>	Sequentially list conditiona,	b. DUE TO	OR AS A COMS	EQUENCE O	7/5	110	inny	- /	The 1st		-	17/
AT	if any, isading to immediate cause. Enter UNDERLYING	m	wad	1-1	2-m	1	10-1	K	1) Vea	,		1//24
읪	CAUSE (Disease or injury that initiated events	DUE TO	OFFIAN A CONS	EQUENCE O	F): /	rur	1		1 ~ 1			1/4/3
E	reaulting in death) LAST		mil.	v0 5	, lea	4	1/-	ti.	20000			1/124-1
CERTIFICATION		d.	Alm		- Con	4.	V		1 Cars C			10/5
	PART II. Other significant condition	s contributing to	dssth but not	resulting	In the und	dsrlyIn	g csuse giver	n In P	art I, 24s. WAS AN		248	WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
EDICAL									1 YES 2	7.7		COMPLETION DF CAUSE
밀												OF DEATH? 1 YES 2 NO
2	DID TOBACCO USE CONTI	RIBUTE TO CA	USE OF DE	ATH Y	ES \square N	IO D	UNCERT	TAIN				
PHYSICIAN: M	25. WAS CASE REFERRED TO MEDICAL			ACE OF DEA		-	0110211	., .,, .				
2	EXAMINER? 1 YES 2 Y NO	HOSPITAL:	ER/Outnotlant	2 □ DOA	OTHER							
¥	27. MANNER OF DEATH	280. DATE OF		28b. TIN		28c. INJ		-	Other (Specify) 28d. DESCRIBE HOW I	NUMBY OF	CUBED	
	1 XNatural 5 Pending	(Month, D	ay, Year)		JURY	WC	PK?		Lou. DEGOTIDE HOW		COMED	
B	2 Accident Investigation	28° BLACE O	F INJURY — AI	hama farm	eteral facts			-	*** I OO471041 /0:	- 4 44 4	n a Direct	2
COMPLETED	3 Suicide 8 Could not be 4 Homicide determined	building,	etc. (Specify)	nome, rem,	atreet, lecto	ну, отне	•	1	28f. LOCATION (Street City or Town, State)		r or Hurai	Houre Number,
91	29a. CERTIFIER											
M	(Check only one)											
ğ	2 MEDICAL EXAMINE	H: On the beals or es	xamination and/c	r investigati	on, in my op	olnion, d	leath occured at	t the ti	me, date and place, ar	id due 10 1	he cause(a) and manner oa stated.
296. SIGNATURE AND TITLE OF CERTIFIED 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, ybar)							(Month, Day, Year)					
80		100	4.1	Ph	wire	-	1) 2	-9	769		1.5	118/95
임	30. NIME AND ADDRESS OF PERSON WH					,	l			Ba	1to	MD
	Marcelino Albue	erne, M.	.D. 51	6 N.	Ro1	lir.	ıg Rd.		Suite 20			1228
	DECT 51995	32. REGISTRA	R'S SIGNATURE									



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	1 - FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.										
	1. DECEDENT'S NAME (First, Middle, La		10	_			2. DATE	OF DEATH	DAY	YEAR	3. TIME OF DEATH
	4. SOCIAL SECURITY NUMBER	1	5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS.					OF BIRTH	6	8. BIRTH	PLACE (State or Foreign
	705-10-9529	1 📆 📜 2 🔲 F	96	YRS.	ONTHS DAYS	HOURS MIN.		. 28,	1899	Country	
Œ	90. FACILITY NAME (If not institution, gi			.9		OR LOCATION OF	DEATH		9c. COU	TY OF DE	
CTO	RESIDENCE OF DECEDENT					ndalk				Ral	timore
DIRECTO	MD 10a. STATE 10b. COU		10c. CITY, TOWN OR LOCATION							10d. INSIDE CITY LIMITS? 1 YES 2 MO	
	10. STREET AND NUMBER		Turners Station					10g. CITI	ZEN OF W	HAT COUNTRY?	
FUNERAL	222 Balnew A	VE.	IN ILC AD	MEO.	140 1100 00		222			USA	
B≺	1 Never Married 2 Married 2 Wildowed 4 Divorced	2 DATES						- American Indian, White, atc.			
ETED	15. DECEDENT'S E (Specify only highest gr	EDUCATION rade completed)	(G	live kind of wor	BUAL OCCUPAT k done during n	ION nost of working	166	. KIND OF BU	SINESS/INO	USTRY	
IPLE	Elementary/Secondary (0-12) 6th	College (1-4 or 5+)		Rail				Bet	hleh	em	Steel
COMPLE	17. FATHER'S NAME (First, Middle, Last)					18. MOTHER'S N					
BE	Allen Foster 190. INFORMANT'S NAME (Type/Print)		19	b. MAILING A	DORESS (Street			Washi			
임	MAry Jane Cor	nish		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 222 Balnew Ave. Baltimore, MD 21222							
	20a. METHOD OF DISPOSITION TO Burial 2 Cremation 3 F	lamoval from Stata Ce	metery, cre	matory or othe	DISPOSITION (F		OAT		OCATION —		
	4 Donetion 5 Other (Specify) Arbutus Memorial Pk, 12/20 Baltimore, MD 21. Standarde Of Funeral Service Licensee										
	James A. Morton & Sons Funeral Holling St. Baltimore, MD 2									neral Hone, MD 21	
	23. PART Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, auch as cardiec or respiratory arrest, anock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition							Approximate Interval Betwee Onset and Deal			
	a. Drew Monico. Due to (or as a consequence of): Sequentially list conditiona, ff any, leading to immediate b. OUE TO (OR AS A CONSEQUENCE OF):										
CATION									-		
ICAT	cause. Enter UNDERLYING CAUSE (Disease or injury	c									
ERTIFIC	that initiated events resulting in death) LAST	DUE TO (OR AS	A CONSE	OUENCE OF):							
MEDICAL C		nentia			1	·	n Part I.	24a. WAS AMPERFO	RMED?	24b.	WERE AUTOPSY FINDING AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
	pu	lumary f	ibro	TIC	dise	are.					1 TES 2 NO
SICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:				PLACE OF DEATH (C	Check only o	ne)			
HYSI	1 NES 2 NO 27. MANNER OF OEATH	1 Inpetient 2 ER/Outpetient 3 DOA 4 Nursing Home 5 Realdence 8 Other (Specify)						IN HIEW OO			
BY PI	1 Natural 5 Pending 2 Accident Investigation					YES 2 NO	RK?				
ED	3 Suicide 8 Could not detarmined	Y — At ho ecify)	At home, term, strast, factory, offica				281. LOCATION (Street and Number or Rural Route Number, City or Town, State)				
COMPLE	29e. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(e) and manner ee stated. 2 MEDICAL EXAMINER: On the bests of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause								end menner as stated.		
BE CO	296. SIGNATURE AND ITITLE OF CERTIFIER 29d. DATE SIGN							(Month, Day, Year)			
2	30. NAME AND ADDRESS OF PERSON	WHO COMPLETED CAUSE OF D	EATH OTE	M 27) (Time Pi	rint)	1 047	000			121	18195
	5505 Bayrie	m Circle	Be		one,	15 am	524				





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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within an horar ater death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTION: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If them 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. 1 -

	1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH								
	INEZ FULFORD	DECEMBER 17 1995 5-50 A-							
	4. SOCIAL SECURITY NUMBER 5. SEX 8. AGE (In yrs.	last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH	BIRTHPLACE (State or Foreign			
	215-28-6475 10 M2 XF 78	YRS.	MONTHS DAYS	HOURS MIN.	(Month, Day, Year		Country) N.C.		
œ	9e. FACILITY NAME (If not institution, give street end number)		_	OR LOCATION OF E		9c. COUNT	OUNTY OF DEATH		
DIRECTOR	RESIDENCE OF DECEDENT		SA	LTO., M	d	N. A			
RE	10a. STATE 10b. COUNTY		TOWN OR LO	•			10d. INSIDE CITY LIMITS?		
	N G N D	4	SALI				1 X YES 2 NO		
FUNERAL	620 E 384 ST								
UND	2/2/8 4.3.4								
BY F	1 Never Married 2 Married PORCES? 1 YES 2 MNO It yes, specify Cuben, Maxican, Puarto Rican, etc.)								
	46 DESCRIPTION FOLIANTIAN								
ETE	(Specify only highest grade completed)		ork done during			16b. KIND OF BUSINESS/INDUSTRY			
COMPLETED	8 7h (MA	1d.		Priv	ATE 1	AMI/X		
00	17. FATHER'S NAME (First, Middle, Last)			18. MOTHER'S N.					
BE	N. A			CALL	18 GR	ISSON			
2	19a. INFORMANT'S NAME (Type/Print)	196. MAILING	ADDRESS (Stree		Route Number, City or	4			
	200. METHOO OF DISPOSITION 20b. PLAC		F DISPOSITION			LOCATION - CH	ry or Town, State		
	1 Suriet 2 Cremation 3 Ramoval from State 4 Donation 5 Other (Specify)	RICIS	ow Fo	rest Co.			mills , md		
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE		22. NAME	AND ADDRESS OF F			200		
	Joseph G. & velo. Jo		doces		I Home				
	23. PART i/Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or reepiretory arrest, ahock, or heart feliure. List only one cause on each line.								
	IMMEDIATE CAUSE (Final			1 4			interval Between Onset and Death		
	disease or condition PETASTATIC BREAST CA 2YEARS DUE TO (OR AS A CONSEQUENCE OF):								
z		readence or	,.				1		
Sequentially list conditions, if any, leading to immediate ceuse. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in deeth) LAST b. DUE TO (OR AS A CONSEQUENCE OF): oue TO (OR AS A CONSEQUENCE OF): d									
S	CAUSE (Disease or Injury that intilated events OUE TO (OR AS A CONS	EQUENCE OF							
E	that initiated events resulting in deeth) LAST	EDUENCE OF	1.				1		
	DATT II Other should and a suite and a sui								
EDICAL	PART II. Other significent conditions contributing to death but no	t resulting in	the underly	ng cause given in	Part i. 24s. WAS. PERF	AN AUTOPSY ORMED?	24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE		
					1 _ YES	2 📜 NO	OF DEATH?		
ž.	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐ UNCERTAIN ☒						1 YES 2 NO		
PHYSICIAN:		ACE OF OEATH	1 (Check only on						
IYSI	1 YES 2 NO 1- Inpetient 2 ER/Outpetient	3 DOA		me 5 🗆 Residence	8 Other (Specify)				
	27. MANNER OF DEATH 1 Netural 5 Pending 28e. DATE OF INJURY (Month, Day, Year)	28b. TIME INJU	IRY V	VORK?	26d. DESCRIBE HOV	V INJURY OCCUI	RED		
2 Accident Investigation Investigation Investigation							Parel Pouts Number		
Uliding, atc. (Specify) City or Town, State)									
COMPLET	29e. CERTIFIER (Check only 1 🔀 CERTIFYING PHYSICIAN: To the best of my knowledge,	death occurred	f at the time, da	te and place, end du	to the cause(s) end n	nenner as stated.			
NO.	one) 2 MEDICAL EXAMINER: On the basis of examination end/of	or Investigation	, in my opinion,	death occured at the	time, date end place,	end due to the d	teuse(e) end menner es stated.		
BE C	29b. SIGNATURE AND TITLE OF CERTIFIER			29c. LICENSE NU			IGNED (Month, Day, Year)		
2	M NAME AND ADDRESS OF BERSON WAY COME FOR DATE OF THE PARTY OF THE PAR			A T243	8946	DEC	ENBER, 17, 1995		
	30. NAME AND AGORESS OF PERSON WHO COMPLETED CAUSE OF DEATH (IT			1/14A015. AA	n 2171)			
	R. PAUL, 20 E, UNIVERSITY PARKWAY, BALTINORE, MD - 21218 31. DAMPHENGMOND DON 1881 / 32 REGISTRAT'S SIGNATURE								
	31. DESTRICT MONTH DON YOUR SURFICIENT SIGNATURE OF MANAGEMENT SIGNATURE OF MA								
	A :		-						

		; 1, 2, 3 should		
DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within the hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNEFALD DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should	De filed writhin 72 hours after death with the State Dept. or Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

31. DATE FILED (Month, Day, Year)

9 1995

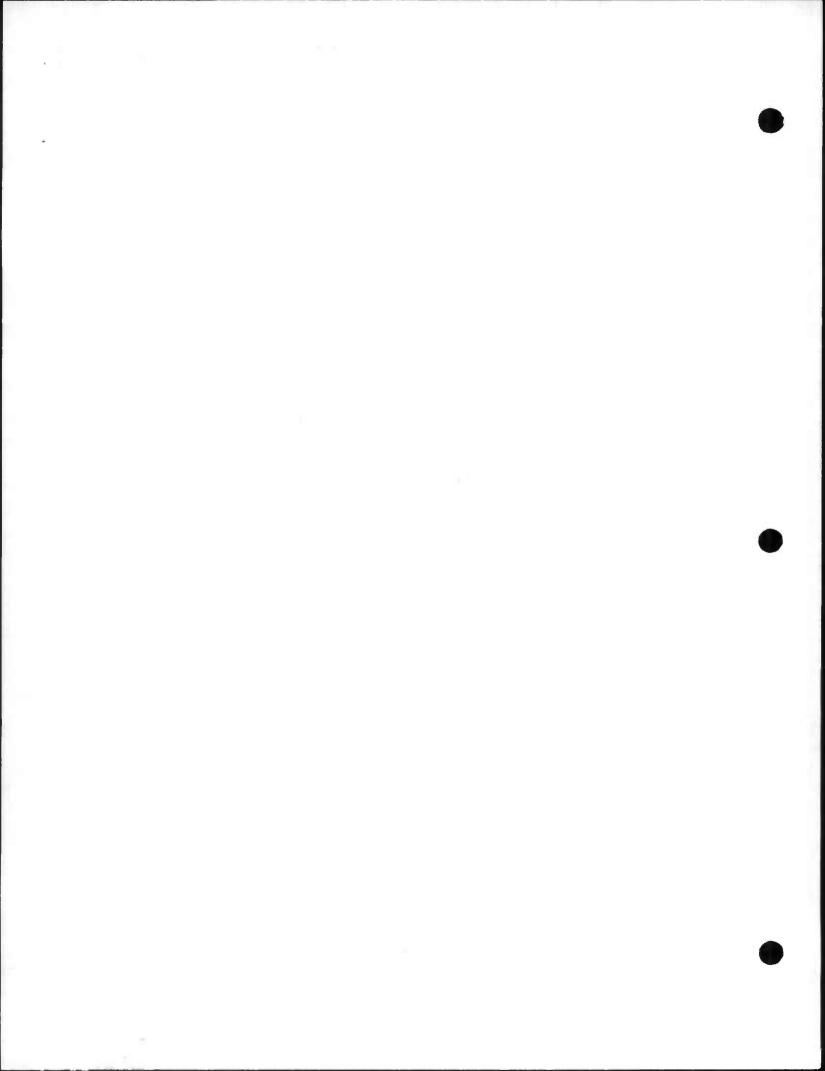
32. REDISTRAR'S SIGNATURE

Davideon Randall

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First Middle Last) 2. DATE OF DEATH 3. TIME OF DEATH 1995 4:00 p. Milton Fleshner vovember 29 4. SOCIAL SECURITY NUMBER 5. SEX 7. DATE OF BIRTN (Month, Day, Year) 6. AGE (In yrs. last birthday) 8. BIRTNPLACE (State or Foreign Country) IF UNDER 24 HRS. 097-09-1612 1 M M 2 - F 78 DAYS Nov., 24, New York 9e. FACILITY NAME (If not institution, give street end number, 9b. CITY, TOWN OR LOCATION OF DEATN 9c. COUNTY OF DEATH 4600 North Park Avenue-Apt. 70HW Montgomery Chevy Chase DIRECTOR RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? Maruland Montgomery Chevy Chase 1 TYES 2 NO 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 4620 N. Park Avenue - Apt. 70HW 20815 U.S.A. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 X YES 2 NO IF YES GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, White, etc., Specify: White If yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 YES 2 NO Specify: 1 Never Married 2 Married BY 3 Widowed 4 Divorced COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5+) Self Employed 2Yrs Retailer 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Melden Surneme)
Dora Koppel Isidore Fleshner BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Purel Poute Number, City or Poym, State, Zip Code)
4620 North Park Avenue-Chevy Chase, Maryland 20815 9 Edith Fleshner 200. METNOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of 28c. LOCATION - City or Town, State 1 Buriel 2 Cremation 3 Removal from State 4 D Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICENSEE JOSEPH B. VanSant 22. NAME AND ADDRESS OF FACILITY
State Anatomy Board-655 W. Baltimore Street Rm. B026-Baltimore, Maryland 21201-1559 23. PART I. Enter the diseases, or complications that caused the desth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feliure. List only one cause on each line. Approximate IMMEDIATE CAUSE (Final **Onset and Death** disease or condition Bronary artery Disease (morediate resulting in death) CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF) If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY PERFORMED? 246. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO MEDICAL Partinsons Disease COMPLETION OF CAUSE 1 YES 2 NO of Prostate vinoma 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 TYES 2 NO 1 | Inpatient 2 | ER/Outpatient 3 | DOA 4 Nursing Nome 5 Presidence 8 Other (Specify) 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 28c, INJURY AT WORK? 284, DESCRIBE HOW INJURY OCCURED 1. Natural 5 Pending 1 YES 2 NO BY 2 Accident Investigation 28e. PLACE OF INJURY — At home, ferm, street, factory, office building, etc. (Specify) 3 Suicide 281. LOCATION (Street end Number or Rural Route Number, City or Town, State) 6 Could not be determined COMPLETED 4 Nomicide 29e. CERTIFIER 1 SERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, data and place, end due to the cause(s) and manner as stated. 296. SUGNATURE AND TITLE OF CERTIFIER 29d. DATE SIONED (Month, Day, Year) 29c. LICENSE NUMBER BE an DZ1115 100 Lenning MIL 2 PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Tipm. Phin)

DNMN-16 Rev 1/89



s law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	scare has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should	th the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	ed, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be execut	TO THE FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and c	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to bunit	IMPORTANT: It item 28 is marked, or item 23 shows any injury, or other traumatic

	ITEM: 1. PER	F'.H. F'I	LM G-730 1	2/19/95	t.t							3		0210
	FOR STATE REGISTRAR		STATE OF N		/ DEPAR					MENTA	L HYGIEN REG. NO	E		
	1. DECEDENT'S NAME (First, Edith		-Mae-	MAY	Fo	rd				MONT	OF DEATH H DA MBER (7 /	YEAR 965	3. TIME OF OEATH 3. SO A M
	4. SOCIAL SECURITY NUMB 214-22-6178		5. SEX	6. AGE (In yrs.		IF UNDER	DAYS	IF UNDE	MIN.	7. DATE (Monti June	OF BIRTH	1919	a. BIRTH Country Mary	PLACE (State or Foreign
	9a. FACILITY NAME (If not in:	stitution, give si	treet and number)			9b. CITY	r, TOWN C	R LOCAT	ION OF DE	ATH		9c. COU	NTY OF DE	EATH
6	Union Men	noria	l Hospi	tal		Ва	ltir	nore	Ci	ty		J	Balto	. City
EG	10a. STATE	10b. COUNTY	,		10c. CIT	Y, TOWN	OR LOCAT	ION						10d. INSIDE CITY
FUNERAL DIRECTOR	Maryland	Е	Balto. Ci	.tv		Ba	altir	nore	City	V				LIMITS?
AL	10e. STREET AND NUMBER							ZIP COD				10g. CIT	IZEN OF W	HAT COUNTRY?
띨	3838 Roland	Avenu								21211			US	SA
ᆵ	11, MARITAL STATUS 1 Never Merried 2	Married		YES X	ARMED NO						f? (Specify Yes Rican, atc.)	or No-	14. RACE Black	— American Indian, , White, atc.
8≺	3 Wildowed 4 Divo		IF YES, GIVE V	WAR OR DATES			1 TYES	² X ^{NO}	Specify	y:			Spech	white
8	15. OEC	EDENT'S EDUC	CATION	16a.	DECEDENT'S (Give kind of				in a	16b	. KIND OF BU	SINESS/IN	DUSTRY	WILLCE
	Elementary/Secondary (0		College (1-4 or 5	+)	Produ	se retired.)				NAT	NTs sde	e De	l to Do	rts Co.
COMPLETED	7th				Produ	CCIC	OII WO					_	IC Pa	irts co.
BE CO	17. FATHER'S NAME (First, M		Wilbur H	larris							Middle, Melden Llmon	Surneme)		
0	Betty Owing										ber, City or Town			21211
	20e. METHOD OF DISPOSITE 1XO Buriel 2 Cremetic 4 Donation 5 Other	n 3 🗆 Rem	oval from State		ce and date crematory or c					12/2			City or To	Maryland
	21. SIGNATURE OF FUNERAL		CENSEE	, Durie		22.	NAME A	ID ADDRE	SS OF FA	CILITY				
	Surus	dlen	n Carn	outes			_				ral Ho		итъ 21	211
	23. PART I. Enter the dishock, or himmediate CAUSE (Fir disease or condition resulting in death)	eart failure.	List only one car	TNTRA	Ine.	not enter	r the mo	de of dy						Approximate Interval Between Onset and Death
_		_		ARDIO			Sho	CK						17 days.
Ó	Sequentially list conditi		b. DUE TO	(OR AS A CONS	SEOUENCE C	F):								
CAI	cause. Enter UNDERLY! CAUSE (Disease or Inju	ING					1400	YOCARDIAL INFARCTION					17 days.	
CERTIFICATION	that initiated events resulting in death) LAS		d	(OR AS A CONS	SEOUENCE C)F);								
MEDICAL	PART II. Other significs								given in		24a. WAS AN PERFOI 1 YES	RMED?	24b.	WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
AN	25. WAS CASE REFERRED TO		KIBUIL IO CA		LACE OF DEA			1 014	CERTAI	N L.				
SIC	EXAMINER?		HOSPITAL:	ER/Outpetlant	3 🗆 DOA	OTHE		w 5 □ 6	lesidence	B C Oth	er (Specify)			9-1
PHYSICIAN:		Pending	28e. DATE OF		26b. TII		28c. IN.	URY AT ORK?			SCRIBE HOW	INJURY O	CCURED	
ED BY	3 Suicide 6	Could not be determined	26a. PLACE (building	OF INJURY — At, etc. (Specify)	home, farm,	straet, fac					CATION (Street or Town, State		or or Rural F	Route Number,
COMPLETED	one)		ICIAN: To the best o											
Ö	2 MED			xamination end/	/or Investigati	on, in my	opinion, o	leath occu	ured at the	time, date	and place, e	nd due to	the ceuse(s	e) end manner as stated.
TO BE	296. SIGNATURE AND TITLE	MI							243		46			(Month, Day, Year) WBER 17,95
-	R. PAUL,	MAIO	N MEMOI	EIAC HO	SPIM		V016	·, v	NIV	PKW	Y, BA	LTIM	URE	MD-21218.
	DEC 1 9	995	32. REGISTR	AR'S SIGNATURI	lalf					-				
_														



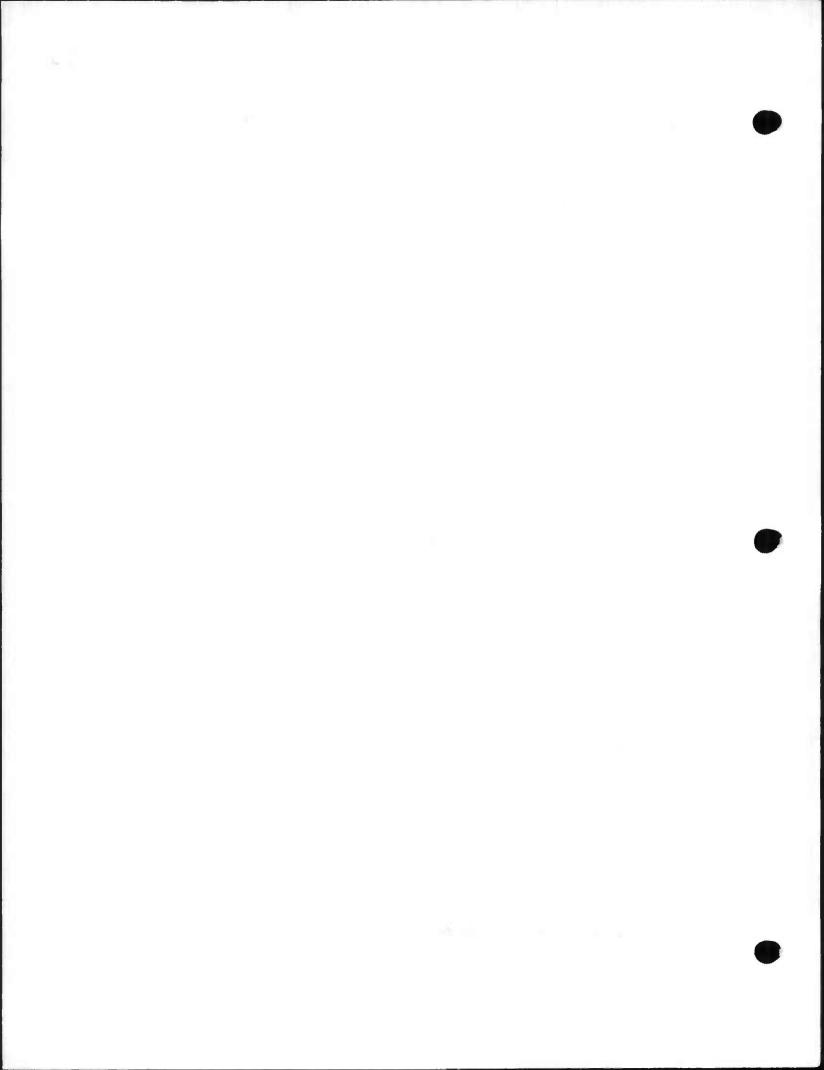
e Still He et en a s .

BALTIMORE, MARYLAND 21215-0020	OR ATTENDING PHYSICIAN: The law requires that the death certificate he exercised within a brance shear death. Done & may be arrived by the brooking of exercises
BALT	house after death
68760	manufactual within
P.O. BOX	th certificate he
VITAL RECORDS, P.O. BOX 68760	requires that the dear
4 OF VITAL	PHYSICIAN The law
DIVISION OF VIT	I OR ATTENDING

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Best, of Health and Mental Hydiene prior to burial, cremation, or removal.

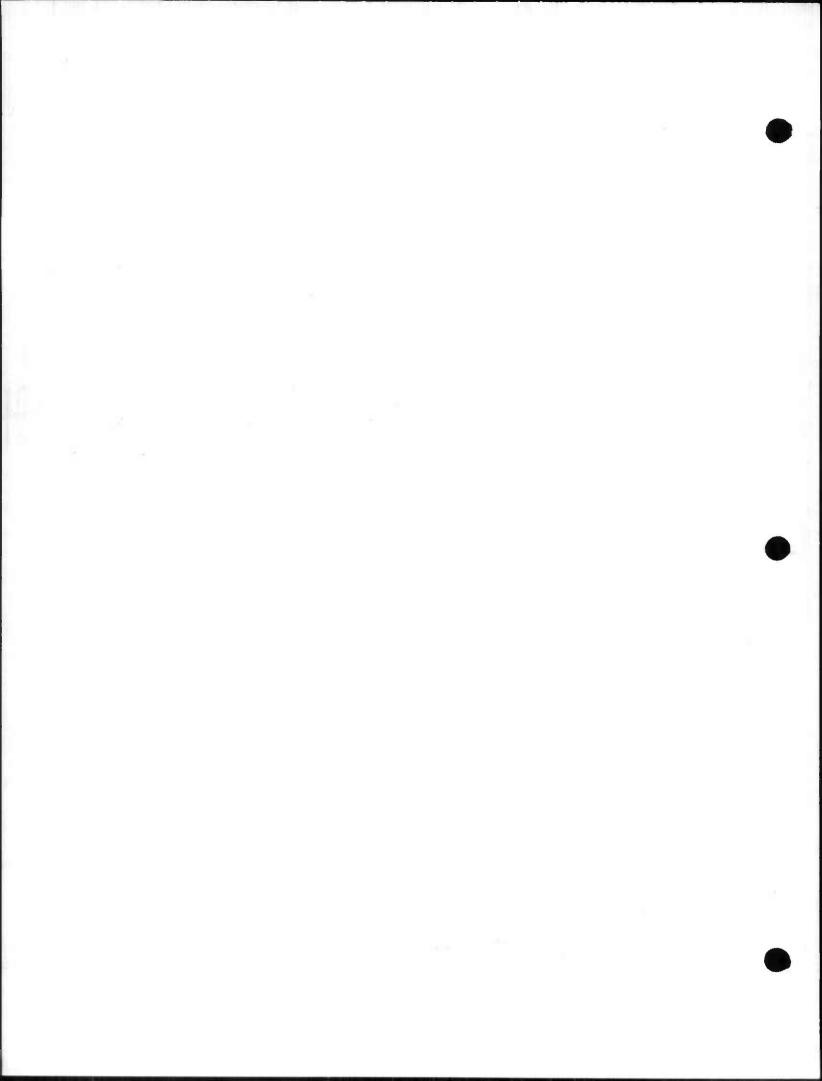
	1 - FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH CERTIFICATE OF DEAT	AND MENTAL HYGIENE TH REG. NO.								
	1. DECEDENT'S NAME (First, Middle, Last) GESSIE Funderburk	2. DATE OF DEATH DAY DECEMBER 7 1995 6:40 A M								
	4. SOCIAL SECURITY NUMBER 5. SEX 1 M 2 F F SC SC SC SC SC SC SC SC SC SC SC SC SC									
E E	9a. FACILITY NAME (If not institution, give street and number) Liberty Medical Center Baltmare	410								
DIRECTOR	10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION	10d. INSIDE CITY LIMITS?								
	Md NA Baltimore 100. STREET AND NUMBER 101. ZIP CODE	1 YES 2 NO								
FUNERAL	11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF	F HISPANIC ORIGIN? (Spectry Yes or No— 14. RACE — American Indian, Black, Whita, etc.)								
B	3 Wildowed 4 Divorced IF YES, GIVE WAR OR DATES 1 YES 2 NO	h, Maxican, Puerto Rican, etc.) Specify: Black, White, etc. Specify: Black								
LETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)	16b. KIND OF BUSINESS/INDUSTRY								
at once.		ER'S NAME (First, Middle, Maiden Syrname)								
TO BE	194. INFORMANT'S NAME (Type/Print) 19b. MAILINO ADDRESS (Syreet and Number of	OG IC TO ZI EV or Rural Route Number, City or Town, State, Zip Gode)								
medical examiner must be notified	20a, METHOD OF DISPOSITION 1 Burlat 2 Commetton 3 Removal from State 20b PLACE AND DATE OF DISPOSITION (Name of comology, cremating, or other place)	DATE 29C, LOCATION - City or Town, State								
Niner mu	21. SIONATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS	Hope 2/11/95 West Minster, My								
са ехаш	23. PARTI. Enter the biseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, Approximate									
ant, the medi	Approximate interval Between Onset and Council of Counc									
natic ev	Sequentially liet conditions, Due to (on as a consequence of): Due to (on as a consequence of):									
y, or other traumatic event, the CERTIFICATION	cause. Enter UNDERLYING CAUSE (Disease or Injury c. Covon any Artery Disease	e Years								
y, or oth	that initiated events resulting in death) LAST d									
를	PART II. Other significent conditions contributing to deeth but not resulting in the underlying ceuse gi	Iven in Part I. 24a. WAS AN AUTOPSY PERFORMED 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATHS.								
2 ≥	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO DE UNCE	FRTAIN								
ed, or item 23 s PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) EXAMINER? HOSPITAL: OTHER:									
	27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 28c. INJURY AT WORK? INJURY 1 Netural 5 Pending	28d. DEŞCRIBE HOW INJURY OCCURED								
60 III	2 Accident Investigation 3 Suicide 8 Could not be datermined 28e. PLACE OF INJURY — At home, farm, atreet, tactory, office building, stc. (Specify)	281. LOCATION (Street and Number or Rural Route Number, City or Town, State)								
E H	29a. CERTIFIER (Check only one)									
E CO	2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurrence. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICEN	NOT ANIMADED								
TO B	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)	1365 December 7, 1995 exty Heights Ave 21216								
	George E. Wicks III M.D. 2600 Libers. Don't Filed Month, Day how July By Heldstrand Signal Re	evty Heights AVE 21216								
	DEC 1 6 1995 Selve Other Contract Contr									



		-	APORTANT: it item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
TO THE HOSPITAL DR ATTENDING PHYSIC	TO THE FUNERAL DIRECTOR: After this cer	be filed within 72 hours after death with the	IMPORTANT: it item 28 is marked,

STATE OF MARYLAND	/ DEPARTMENT	OF HEALTH	AND	MENTAL	HYGIENE
	CERTIFICATE	OF DEAT	TH		BEG NO

	1 - STATE OF MARY!		ENT OF HEALTH AND	MENTAL HYGIENE REG. NO.		
1	t. DECEDENT'S NAME (First, Middle, Last)			2. DATE OF DEATH	3. TIME OF	DEATH
- [LINDA DARNELL GIL	LUS		12 - 16 -	95 4:4	45 A M
	4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE		UNDER 1 YEAR IF UNDER 24 HRS.	7. DATE OF BIRTH	8. BIRTHPLACE (State	
ĺ	214-50-2561 ¹□M ¾ ⊋F	48 YRS. MON	THE DAYS HOURE MIN.	July 5, 194	Country)	.с.
	Sa. FACILITY NAME (If not institution, give street and number)	9b.	CITY, TOWN OR LOCATION OF DE	EATH 9c. CO	OUNTY OF DEATH	
DIRECTOR	Stella Maris at Mercy		Baltimor	e	n/a	3
H	10a. STATE 10b. COUNTY	10c. CITY, TO	WN OR LOCATION		10d, INSIDE	E CITY
	MD n/a	E	Baltimore		1,⊟,YES	2 NO
₹	toe. STREET AND NUMBER		10f. ZIP CODE	10g. C	CITIZEN OF WHAT COUNT	TRY?
FUNERAL	725 S. Lakewood Ave.	•	21224		USA	
5	11. MARITAL STATUS 1 Never Married 2 Married FORCES? 1 YES	IN U.S. ARMED	13. WAS DECENDENT OF HISPAI If yes, specify Cuban, Mexico	NIC ORIGIN? (Specify Yea or No -	14. RACE — America Black, White, atc.	n Indian,
ΒX	3 ☐ Widowed 4 ☒∑Sivorced IF YES, GIVE WAR OR	DATES	t YES 2 NO Specific	у:	Specify:	
	15. DECEDENT'S EDUCATION	16+. DECEDENT'S USU	AL OCCUPATION	16b, KIND OF BUSINESS/	l Bla	ick
COMPLETED	(Specify only highest grade completed)	(Give kind of work	done during most of working	166. KIND OF BUSINESS/	INDUSTRY	
2	Elementary/Secondary (0-12)	Radiolo	gy Tech	Hospi	+ > 1	
MO	17. FATHER'S NAME (First, Middle, Last)	1100.1010		ME (First, Middle, Malden Surname		
	Willie L. Gamble		32500	estine Tuck	-,	
BE	19a. INFORMANT'S NAME (Type/Print)	19b, MAILING ADI	DRESS (Street and Number or Rural			
유	Willie L. Gamble		the Alameda			
	20e. METHOD OF DISPOSITION 20	D. PLACE AND DATE OF D			- City or Town, Stata	
	125 Huriel 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	emetery, cremetory or other HOLLY Hil	olece)	12/23 Ball	timore. M	(ID
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE	110111	22. NAME AND ADDRESS OF FA	CILITY		
- 0.1	C Ma			orton & Sons		Home
	Jumes W. Mar	080		ns St. BAlto		1217
	23. FART Enter the diseases, or complications that cause on hock, or heert fellure. Liet only one ceuse on		enter the mode of dying, suc	ch as cardiac or respiratory		roximata val Batween
	IMMEDIATE CAUSE (Finel			2 10	Onse	et and Death
	disease or condition	as tarre	lung C	an der	2	mos.
	DUE TO (OR AS	A CONSEQUENCE OF):				
ON	Sequentially liet conditione, b.	A CONSEQUENCE OF):				
FA	if any, leading to immediate cause. Enter UNDERLYING	,			j	
음	CAUSE (Disease or Injury that Initiated events DUE TO (DR AS	A CONSEQUENCE OF):				
CERTIFICATION	reaulting in death) LAST					
¥	PART II. Other algnificant conditions contributing to deeth	but not resulting in t	he underlying ceuse given in	Part I. 24a. WAS AN AUTOP: PERFORMED?	AVAILABLE	PRIOR TO
ĕ	AIDS	<u> </u>		t YES 2 NO	OF DEATH?	ON OF CAUSE
PHYSICIAN: MEDIC					1 🗆 YES	2 🗌 NO
ä	DID TOBACCO USE CONTRIBUTE TO CAUSE			N X		
S	25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL:	26. PLACE OF DEATH (Check only one)			
YSI	t TYES 2 NO 1 Inpatient 2 ER/Du	stpatient 3 DOA 4	☐ Nursing Home 5 ☐ Realdence	8 XOther (Specify) HOSP1	ICE AT	MERCY
F	27. MANNER OF DEATH 28a. DATE OF INJUR' (Month, Day, Year) 1 Netural 5 □ Pending		WORK?	28d. DEŞCRIBE HOW INJURY	OCCURED	
B	2 Accident investigation		M 1 YES 2 NO			
	3 Suicide 6 Could not be 4 Homicide detarmined	RY — At home, farm, atree pecify)	it, factory, offica	28f. LOCATION (Street and Nun City or Town, State)	nber or Rural Route Numbe	ν,
<u> </u>	29a. CERTIFIER					
P	stated.					
Specific and the design of the						
BEC	29b. SIGNATURE AND TITLE OF CERTIFIER		29c. LICENSE NU	MBER 29d. (DATE SIGNED (Month, Day	r, Ybar)
TO B	Ol. Offmins		24.04	-80	12/18/95	
F	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF I	DEATH (ITEM 27) (Type, Pri		k KD		
	FORMADO U. FORRO, MD		anio, mo	21206		
	31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SK					
	DEU1 91995 Jahr Davidson Ro	Mall				



BALLIMORE, MANICAND ZIZIS-0020	24 hours after death. Page 6 may be retained by the hospital or attending physician.	certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should in the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	he medical examiner must be notified at once.
DIVISION OF VITAL RECORDS, F.O. BOX 80/81	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within Z4 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this centificate has been signed by the attending physician and completely filled in by the 1 be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: It Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

FOR STATE REGISTRAR	STATE OF MARYLAI		TMENT OF H ICATE OF			HYGIENE REG. NO.		
t. DECEDENT'S NAME (First, Middle, Last)	*				2. DATE OF	DEATH		3. TIME OF DEATH
HOWARD FREDERICK C	GAGUSKI						, 199	5 6:43 P. M
	SEX 6. AGE (In	yrs. lest birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7, DATE OF	BIRTH	a. B	IRTHPLACE (State or Foreign
218 54 4350	∑ M 2 □ F	F YRS.	MONTHS DAYS	HOURS MIN.				Marvland
Se. FACILITY NAME (If not institution, give street	and number)		9b. CITY, TOWN C	R LOCATION OF DE			_	
	ice		ToT	vson			Ba1	timore
10e. STATE 10b. COUNTY		t0c. CIT	Y, TOWN OR LOCAT	TION				10d. INSIDE CITY
Maryland Ba	altimore			Raltimo	ore			t TYES 2 THO
too. STREET AND NUMBER			100		J1 C	1	log. CITIZEN (OF WHAT COUNTRY?
11 Wytchwood Ct.	Apt. T2			21209	9		Unite	d States
	. WAS DECEDENT EVER IN L	J.S. ARMED	13. WAS DEC	ENDENT OF HISPAN	VIC ORIGIN? (S	Specify Yes or	No- 14. F	RACE — American Indian.
						rn, etc.)		Black, White, atc.
				Λ.				White
15. DECEDENT'S EDUCATI (Specify only highest grade con	npleted)	(Give kind of v	vork done during mo	ON st of working	16b. Kil	ND OF BUSIN	ESS/INDUSTR	AA.
The state of the s				1800				
		Negra	rered M		ME (5)			1
	Ga	meki				fle, Maiden Sui	rname)	2
	- Ga		ANDRESS /Street o			Other or Town	Otata Zin Carde	Gover
Rev. Paul Moser							state, zip cool	"
20a. METHOD OF DISPOSITION	20h. P					7	TION — City o	or Town, State
	from State cemet	ery, crematory or of	ther place!		1			
21. SIGNATURE OF PUNERAL SERVICE LICEN	164	cen mou	22. NAME AN	ID ADDRESS OF FA	CILITY			re' MD
1 AN X 11	/		CAFA S	tephen I	Loh:	rmann	P.A.	
A CONTRACTOR OF THE PARTY OF TH								
ahock, or heart fallure. List	t only one cause on eac	this desth. Do n th line.	ot enter the mo	de of dying, suc	h ss cardisc	or reapiral	tory arrest,	Approximats interval Between
iMMEDIATE CAUSE (Final								Onset and Death
resulting in death)				DEFICIE	NCY S	SYNDRO	ME	4 yrs.
	DUE TO (OH AS A C	ONSEQUENCE OF	F):					l l
Sequentially list conditions b.								
Sequentially list conditions,	DUE TO (OR AS A C	CONSEQUENCE OF	n:			-		
If any, leading to immediate cause. Enter UNDERLYING	DUE TO (OR AS A C	CONSEQUENCE OF	F):					
If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury	DUE TO (OR AS A C							
If any, leading to immediate cause. Enter UNDERLYING								
If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (OR AS A C	CONSEQUENCE OF	F):					
If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significant conditions of	DUE TO (OR AS A C	CONSEQUENCE OF	F):	g cause given in		Is. WAS AN AL	ED?	24b, WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (OR AS A C	CONSEQUENCE OF	F):	g cause given in			ED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other aignificant conditions of the conditions of the cause of th	ontributing to death but	t not resulting	n the underlying		1	PERFORM	ED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE
If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other aignificant conditions of the conditions of the cause of the conditions of the cause	ontributing to death but	t not resulting ACH	in the underlying		1	PERFORM	ED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
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If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other algnificant conditions of the con	ontributing to death but OF STOM SUTE TO CAUSE OF 20 OSPITAL:	DEATH YE	in the underlying S NO TH (Check only one) OTHER: 4 Nursing Hom	UNCERTAIL	N D 6 X Other (S	PERFORMI	spice	AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? t Yes 2 No
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FACILITY NAME (If not institution, give street and number) Stella Maris Hospice RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY Maryland Baltimore 11 Wytchwood Ct. Apt. T2 11. WAS DECEDENT EVER IN FORCES? 11 Wytchwood Ct. Apt. T2 12. WAS DECEDENT EVER IN FORCES? 13 Widowed 4 Divorced 15. DECEDENT'S EDUCATION 15. DECEDENT'S EDUCATION 15. DECEDENT'S EDUCATION 15. DECEDENT'S EDUCATION 17. FATHER'S NAME (First, Middle, Last) Edward 19a. INFORMANT'S NAME (First, Middle, Last) Edward 19a. INFORMANT'S NAME (First, Middle, Last) Edward 19a. INFORMANT'S NAME (First, Middle, Last) Edward 20b. FC. 20c. METHOD OF DISPOSITION 1 Buriel 2X Cremation 3 Removal from Stata 4 Donetion 5 Other (Specify) 21. SIGNATURE OF FUNERAL PHYSICE EXCEMBER 22. PART I. Enter the diseasea, br complications that caused in shock, or heart failure. Liet only one cause on each immediate cause of cause or condition resulting in death) DUE TO (OR AS A CONDITION IN THE STAGE IN	t. 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DECEDENT'S NAME (First, Middle, Last) HOWARD FREDERICK GAGUSKI 4. SOCIAL SECURITY NUMBER 2. S. SEX 3. SEX 4. S. AGE (In yrs. last birtholay) Se. FACILITY NAME (In or institution, pivs street and number) Stella Maris Hospice 10. STATE 10. COUNTY Maryland Baltimore 10. STATE 10. COUNTY Maryland Baltimore 11. Wytchwood Ct. Apt. T2 12. WAS DECEDENT EVER IN U.S. ARRED 13. Widdle 4 Divorced 15. DECEDENT'S EDUCATION (Specify only highest grade completed) 15. DECEDENT'S EDUCATION (Specify only highest grade completed) 16. STATE 17. FATHER'S NAME (First, Middle, Last) Edward 18. INFORMANT'S NAME (First, Middle, Last) Edward 19. INFORMANT'S NAME (First, Middle, Last) Edward 19. INFORMANT'S NAME (First, Middle, Last) Edward 19. INFORMANT'S NAME (First, Middle, Last) Edward 19. INFORMANT'S NAME (First, Middle, Last) Edward 19. INFORMANT'S NAME (First, Middle, Last) Edward 20. METHOD OF DISPOSITION (In Bull and Section of the Complete of Disposition) Rev. Paul Moser 20. 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Paul Method Disposition (In Bull and DISPOSITION) Rev. Paul Method Of Disp	Comparison Com	Company Comp



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 9 5 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month

Physician /Medical Examiner

> **Funeral** Director

filed within 72 hours after death with the Marylend r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at Hygiene.

21215-0020

marked other Department of Important: If any Injury or

> the use as ate has been signed by page 2 should be detac certificate this After

i. Pages 1 end 2 should be filed w tment of Health and Mentel Hygiei tant: if item 27 Is marked other th ijury or other treumatic event, III Baltimore, Maryland Physician /Medical Examiner The lew requires that the death certificate be executed P.O. Box 68760. Records, of Vital or Attending Physician: Division death. after death Director: illed in by To the Hospital within 24 hours a To the Funeral D Hospital

Jane Wright Gaffney 12 12 95 0930 4e. Fecility Nama (If not Institution, give straat and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth St. 6. Sex 1101 Paul Street Baltimore
If Undar 24 Hrs. 8. Deta 8. Deta of Birth (Month, Dey, Year) 5. Social Sacurity Number If Under 1 Yaar 7. Aga (In yrs. lest birthday) Birthpleca (Stata or Foreign Country) 1 M 25 F Months Deys Hours Min. 219 22 8307 MARY Usuel Residence of Decedent 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Yes 2 No Director MARYLAND BALTIMORL 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 13. Was Dacedent of Hispenic Orlgin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) -S.A RUST Funerai 1101 12. Was Decedent Ever in U,S. Armad Forcas? 11. Marital Status 14. Rece - Amarican Indian, Black, White, etc. Yes 2 250 No 1 Never Merried 25€ Married 1 Yes 2No Specify: p 3 ☐ Widowed 4 ☐ Divorced WHITE Yaar or Detes Completed 16a. Decedent's Usuel Occupetion (Give kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 4YRS. (127 RS. HOSPITAL 17. Fether's Nema (First, Middle, Last) 18. Mother's Neme (First, Middle, Melden Sumema) Be HINRY S. WRIGHT CRONIN FLORENCE 19e. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) .O. BOX 30 GEORGE W. GAFFNEY FAIRHOPE, ALABAMA 36533-0030 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) Dete TA 20e. Method of Disposition 20c. Location - City or Town, Stete Buriel 2 ☐ Cremetion 3 ☐ Removel from Stete 4 □ Donetion 5 □ Other (Specify) DULARRY VALLEY limonium 21. Signature of Funerel Service Licenses 22. Nama and Address of Fecility 90 YORK 2325 ROAD Timoriur Bros 23e. Pert1. Enter the disease, or compfications that caused the deeth. Do not enter the mode of dylng, such as cardiec or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximete Intervel Between Onsat and Death Immediate Ceuse (Final ATHOROGOMOTIC CAMPIONAScump DISONS disease or condition resulting in deeth) Due to (or as a consequence of) Examiner Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseesa or injury thet initiated events resulting in deeth) Lest Due to (or as a consequence of): Physician/Medical Due to (or es a consaguence of) Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 3 □ Probably 4 Unknown 1 ☐ Yes 2 ☐ No ģ 24b. Were autopsy findings aveileble prior to Completed 24e. Wes en eutopsy performad? completion of cause of deeth? 1 ☐ Yes 2 ☐ No 1 Yes 27 No Be 25. Was case referred to medical 26. Piece of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) YYes 2□ No Certification: To 27. Menner of Death 28e. Dete of Injury (Month, Dev Yeer) 28b. Time of 28c. Injury et Work? 28d. Dascribe how Injury occurred Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Sulcide

Penn 31. Date flied (Month, Dey, Yeer) UEC1 91995 State Registrar

4 D Homicide

29b. Signatwe and title of certifier

29e. Certifier

Medical

Baltimore, Maryland 21201 HDW DUTY W. (Consulus Street 32. Registrer's Signature

30. Name and eddress of person who completed cause of death (Item 23e) (Type, Print)

28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) end menner es stated.

Medical Examiner: On the best of axaminetion end/or investigation, in my opinion, deeth occurred et the time, date and place, end due to the cause(s) end manner stated.

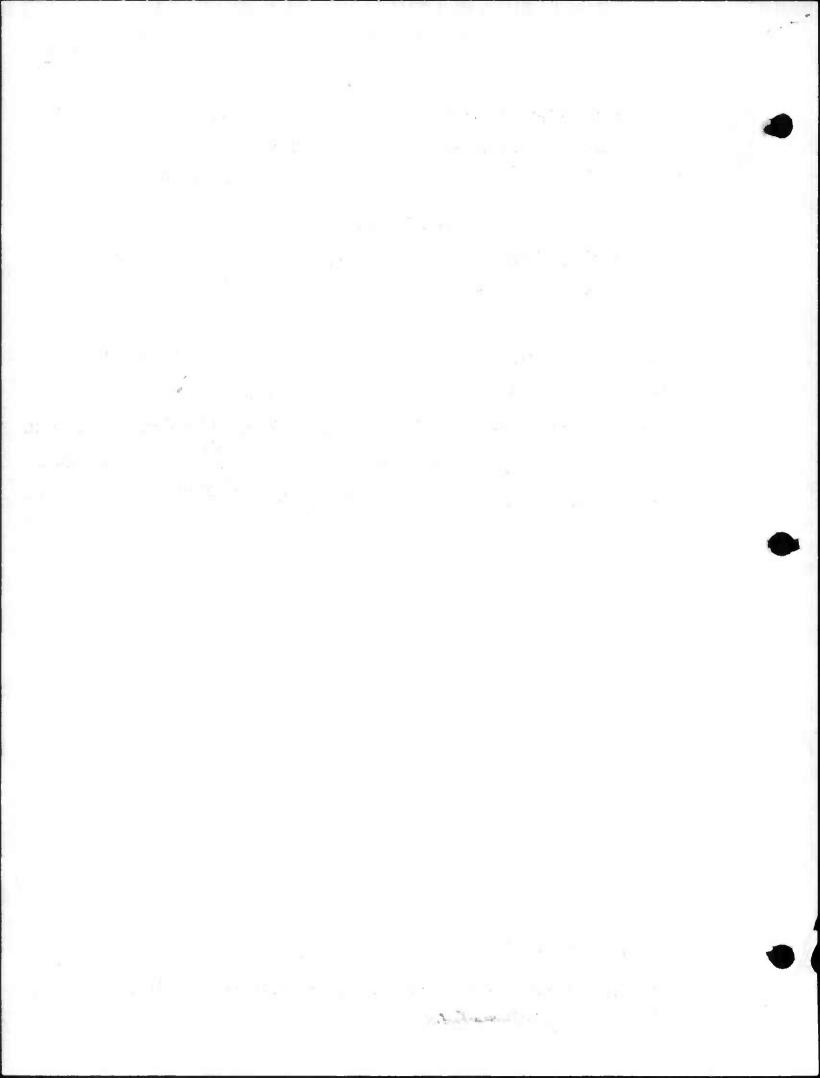
29c. License number

OCME

28f. Location (Street end Number or Rural Route Number, City or Town, State)

29d. Dete signed (Month, Dev. Year)

12-12-95



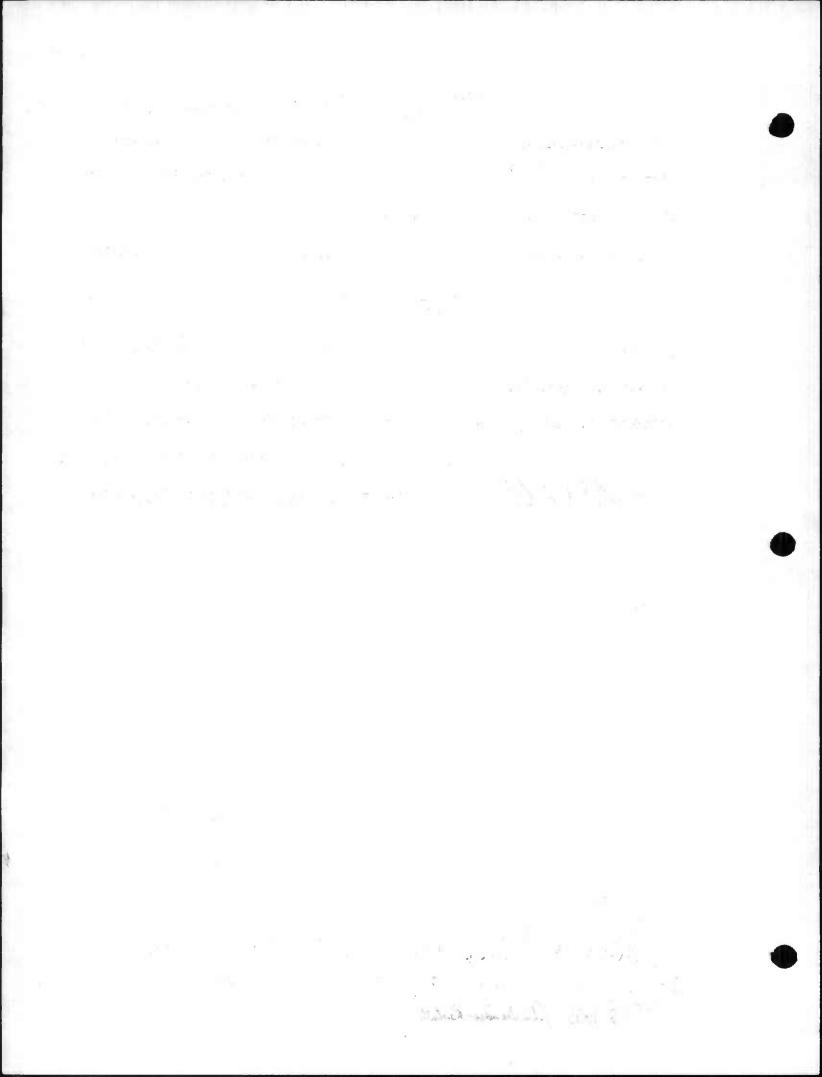
Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. 3 8 2 2 3

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Time of Death William Geyer. Ir. December 13, 1995 **Physician** :05 August /Medical 4e. Facility Nema (If not Institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth **Examiner** Dundalk Baltimore 35 Lombardy Drive | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Dey, Year) | Nov. 25, 1930 5. Social Security Number 7. Age (In yrs. lest birthday) 9. Birthpiaca (Steta or Foreign Country) Maryland **Funeral** 120 M 20 F 65 Yrs Director 216-28-5661 Usuel Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filled within 72 hours after death with the Manylar Department of Heelih and Mental Hygiene. Important: if item 27 is marked other than "natural", or itema 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at page. Maryland Baltimore Dundalk 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? United States 21222 35 Lombardy Drive Funeral 12. Wes Decedent Ever in U.S. Armed Forces?

1 Xas 2 No if Yes, Give Yeer or Detes: 1948 Was Decedent of Hispenic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck. White, etc. 1 Navar Married 2 Merried White Baltimore, Maryland 21215-0020 1 □ Yes 2 No Specify 1948à 3 ☐ Widowed 4 ☐ Divorced 1952 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) 12 years American Standard Plumbing Collega (1-4or 5+) Pipe Fitter 17. Fether's Nema (First, Middle, Last) 18. Mother's Neme (First, Middle, Meldan Surname) Glencora Frazier William A. Geyer. Sr. 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 35 Lombardy Drive Dundalk, Maryland 21222 Robertetta L. Geyer / Wife 20b. Pieca of Disposition (Neme of cemetery, crematory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stata 1 XBurial 2 Cremetion 3 Ramovei from Stete 12/16/95 Middle River, Md. 4 ☐ Donation 5 ☐ Other (Specify) Holly Hill Cemetery 21. Signature of Funera 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Avenue Dundalk, Maryland 21222 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximete interval Betwoonset and D **Physician** /Medical ANCEN immediate Cause (Fine) 5 - UN C diseesa or condition resulting in deeth) Examiner Due to (or es a consequence of): Examiner physician and the burel-transit Sequentielly list conditions, if eny, leading to immediate causa. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in death) Last Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical Dua to (or es e consequance of): for use as Part ii. Qther significant conditions contributing to death but not resulting in the underlying cause given in Pert i. ed by the deteched 23b. Did tobacco use contribute to the cause of death? signed by t 2 No 3 Probably 4 Unknown Yss þ been si 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an eutopsy performed? Completed hes 1 ☐ Yes 2 ☐ 1 □ Yas 2 □ No To the Hospital or Attending Physician: within 24 hours after deeth.

To the Funeral Director: After this certifica completely filled in by the funeral director; 25. Wes case referred to medical Be 28. Place of Deeth (Check only one) examiner? Hospitel: 1 ☐ inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2□ No 2 28a. Dete of injury (Month, Day Year) 28c. Injury at Work? 27. Menner of Deeth Certification: 28b. Time of 28d. Describe how Injury occurred 5 Pending Neturei 1 Yes 2 No Investigetion 2 Aecidant 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end piece, and due to the ceuse(s) and menner as stated.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, dete and piece, and due to the cause(s) and manner stated. Medical 29b. Signature and title of certifian 29d. Date signed (Month, Dey, Year) 36430 MO nd address of son who completed cause of eeeth (item 23e) (Type, Print) Balt, MORE NICHAMOSON Dundach 2112 21222 MO 31. Date (illed (Months Dey, Year) DECT 9 1995 Registrer's Signeture State

Registrar



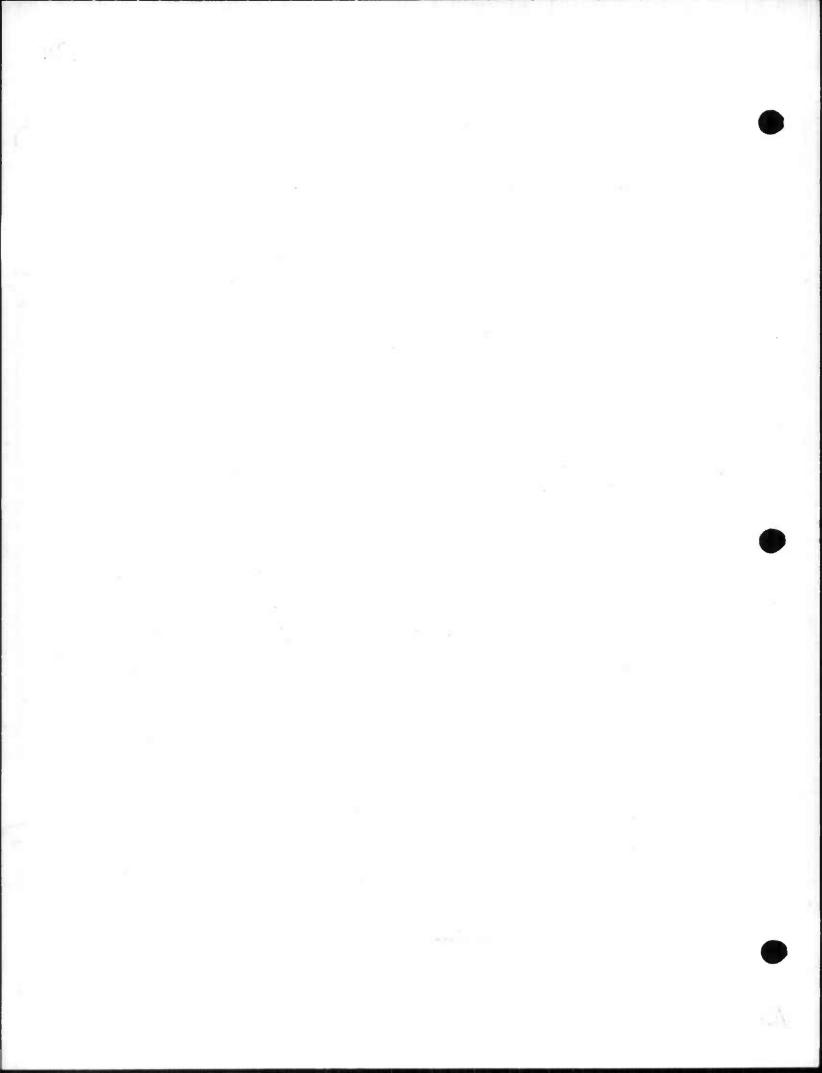
BALTIMORE, MARYLAND 21215-0020	VISICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	is certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
DIVISION OF VITAL RECORDS, P.O. BOX 68760	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funer be filed within 72 hours after death with the State Dept. of Health and Mental Hyglene prior to burial, cremation, or remoral.

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	1 - FOR STATE REGISTRAR	STATE OF MA			TMENT				MENTAL	HYGIEN REG. NO	E		
	1. DECEDENT'S NAME (First, Middle, Last)								2. DATE O	F DEATN D	av .	YEAR	3. TIME OF DEATN
		ladstei	L				Decen	nber	17,19	795	8:10 P M		
		6. SEX 6.	AGE (In yrs. last	birthday)	MONTHS	DAYS	HOURS	24 HRS. MIN.	FEB 2	EBIRTH 22, Year 19	923	Penn	PLACE (State or Foreign Sylvania
E .	99. FACILITY NAME (If not institution, give stree UNION MEMORIA		TAL		96. CITY,		LOCATIO		ATH		9c. COU	INTY OF DI	
15	RESIDENCE OF DECEDENT		noot 11111								1/21		
DIRECTOR	10a. STATE 10b. COUNTY		10c. CITY, TOWN OR LOCATION					.11				10d. INSIDE CITY	
	Maryland Baltin	nore				-			ille		,		1 YES 2 NO
FUNERAL	719 Maiden Choice I	Ln., HR 2	40			101.	ZIP CODE	2122	8		10g. CIT	USA	HAT COUNTRY?
BY FUN	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	2. WAS DECEDENT ET FORCES? 1 IT IF YES, GIVE WAR	YES 2 N	MED O	lf.	yes, spec	NDENT OF	i, Maxicai	ANIC ORIGIN? (Specify Yea or No— 14. RACE — American India Black, Whita, atc.) fly: Specify: White			, Whita, atc.	
9	15. DECEDENT'S EDUCAT (Specify only highest grade cor		16a. DEC	EDENT'S	USUAL OC	CUPATION			16b. F	UND OF BUS	SINESS/IN	DUSTRY	
OMPLETED		College (1-4 or 5+)	H70.	DO NOT US							-		
e d M		4	Regi	lster	ed D	1eti				spita			
BE CO	17. FATHER'S NAME (First, Middle, Lost) Ralph T. Whi	itney					18. MOTN	ER'S NAI	ME (First, Mic Jess:	ie I.		lison	
10 11	19a. INFORMANT'S NAME (Type/Print) Ralph W. Whitney		19b. R	MAILING	Box	(Street an	Luc	or Rumal A	a, PA	1623	n, State, Zij	p Code)	
examiner must be notified at once. TO BE COM	20a. METNOD OR DISPOSITION 1 Burlai 2 Cremetion 3 Removal from State 4 Donetion 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of Methods of Place and Date of Disposition (Name of Methods of Place and Date of Disposition (Name of Methods of Place and Date of Disposition (Name of Methods of Place and Date of Disposition (Name of Methods of Place and Date of Disposition (Name of Methods of Place and Date of Disposition (Name of Methods of Place and Date of Disposition (Name of Methods of Place and Date of Disposition (Name of Methods of Place and Date of Disposition (Name of Methods of Place and Date of Disposition (Name of Methods of Place and Date of Disposition (Name of Methods of Place and Date of Disposition (Name of Methods of Place and Date of Disposition (Name of Methods of Place and Date of Disposition (Name of Methods of Place and Date of Disposition (Name of Methods of Place and Date of Disposition (Name of Methods of Place and Date of Disposition (Name of Methods of Place and Date of Disposition (Name of Name of Place and Date of Disposition (Name of Name of Place and Date of Disposition (Name of Name of Date of Date of Disposition (Name of Name of Name of Date of												
192	21. SIGNATURE OF EUNERAL SERVICE LICEN	SES OU.		OI CIII					1				
	George E. MacN	abb			299	emat: Fre	on :	Soci ick	ety o	f Mar altim	ylan ore.	id, Ii MD 1	nc. 21228
200	George E. MacNabb 299 Frederick Rd. Baltimore, MD 21228 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or reapiratory arrest, integral Between integral Between												
Ĕ	IMMEDIATE CAUSE (Final	K Only Dila Cause	on aach lina.										interval Between Onset and Death
EH, H	disease or condition a. Metabolic Acidosis DUE TO (OR AS A CONSEQUENCE OF): 31e ho							3le hours					
ON S	Sequentially llat conditions, Due to (or as a consequence of): Necrosis of Small and Large Intestines 48 hours Due to (or as a consequence of):												
ERTIFICATION	It any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events Due to (or as a consequence of): Superior Mesenteric Artery Stenosis / week									I week			
or other traumatic event, the medical	that initiated events resulting in death) LAST												20 years
5 5	PART ii. Other eignificant conditions of				1							-	
snows any injury. : MEDICAL CE	Hypertens		ath but not re	auting i	n the und	ariying	cause g	ivan in i		PERFOR	MED?	246.	WERE AUTOPSY FINDINGS AWALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
2	DID TORACCO LISE CONTRIB	LITE TO CALIE	E OF DEAT	II VE	c low		11116	-D=AIA					1 - YES 2 - NO
AN	DID TOBACCO USE CONTRIB	OUE TO CAUS			H (Check or		UNC	KIAIN	4 🗆				
SICIAN:		IOSPITAL:			OTHER:		4 🗆 n						
> ≥	27. MANNER OF DEATN	28a. DATE OF INJ	URY	28b. TIME	OF 2	8c. INJU	TA YF	ilioenca i	8 Other (PIBE HOW II	YJURY OC	CURED	
D BY PH	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Y	our)	INJ	M	1 YE	S 2 _	NO					
о Ш	3 Suicide 6 Could not be 4 Homicide determined	28e. PLACE OF IN building, atc.	JURY — At horr (Specify)	ne, farm, s	treet, factor	ry, offica				ION (Street a Town, State)	nd Number	r or Rural A	oute Number,
O BE COMPLET	29e. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAL ONE) 2 MEDICAL EXAMINER: C												and manner as stated.
E H	296. SIGNATURE AND TITLE OF CERTIFIER	9/					29c. LICE	NSE NUM	BER		29d. DAT	E SIGNED	(Month, Day, Year)
2	30. NAME AND ADDRESS OF PERSON WHO C	OMPLETED CAUSE O	OF DEATH (ITEM	27) (None	Print)	D	412	436	3946	-D8	-0	ecem	ber 17,1995
Julie E. E. Kupersmith, M.D. 2330 W. Joppa Rd. Lutherville, MD 21093													



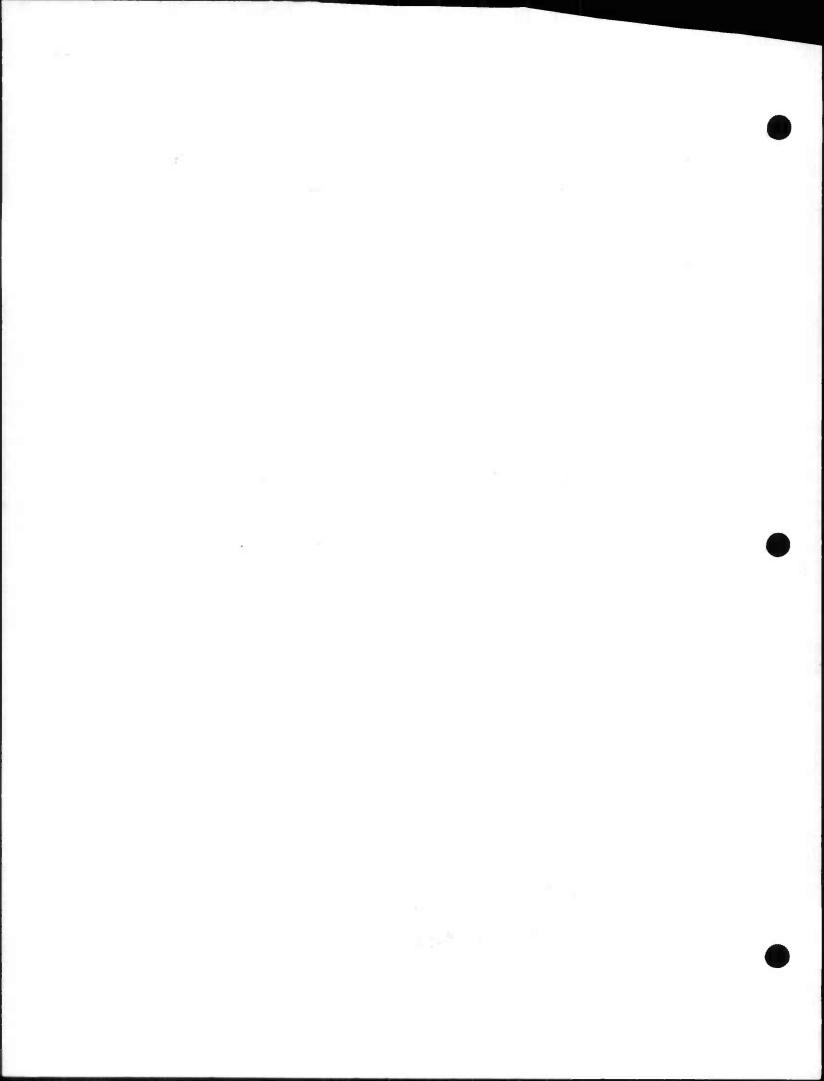
31. DATE FILED (Month, Day, Year)

32. PEGISTRAR'S SIGNATURE



DIVISION OF VITAL RECORDS, P.O. BOX 68760

	FOR 1 - STATE REGISTRAR	STATE OF MARYLAN	D / DEPARTI			MENTAL HYG					
	DECEDENT'S NAME (First, Middle, Lest) LEON	I RICHARD	GARY			2. DATE OF OEAT DECEMBER	н	XEAR 5	3. TIME OF DEATH 10:00pm M		
				IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH		a. BIRTH	IPLACE (State or Foreign		
	218-12-4240 9a. FACILITY NAME (If not institution, give stre		39 YRS.	ONTHS DAYS	HOURS MIH.	MAY 6,1		06 POLAND			
DIRECTOR	MILFORD MANOR NURS				BALTIMOR			TIM			
EC	10a. STATE 10b. COUNTY		10c. CITY,	TOWN OR LOCAT	ION				tod. INSIDE CITY		
	MARYLAND 10e. STREET AND NUMBER	N/A							LIMITS? 1 XYES 2 NO		
FUNERAL	6968 BROOKMILL ROA	D.		100.	21215		log. Citiz	EN OF V	USA		
BY FUN	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN U.S FORCES? 1X YES 2 IF YES, GIVE WAR OR DATES	S. ARMED	If yes, spe	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No— If yes, specify Cuban, Maxican, Puerto Rican, etc.) 1 YES 2 X NO Specify: 1. Specify: WHT.						
1	15. DECEDENT'S EDUCA (Specify only highest grade of	NTION 16.	a. DECEDENT'S US	SUAL OCCUPATION done during mos		16b. KIND OI	F BUSINESS/INDL	JSTRY	WILLE		
COMPLETED	Elementary/Secondary (0-12)	College (1-4 or 5+)	life. Do NOT use	retired.)	MERCHANT				RETAIL		
OM	17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NA						
BE C	ISRAEL		GARY			BLANCHE		UNK	NOWN		
TO B	19a. INFORMANT'S NAME (Type/Print) MRS. GERTRUDE	GARY			nd Number or Rural I				5		
	20a. METHOD OF DISPOSITION 1 TyBurlel 2 Cremation 3 Remon		ACE AND DATE OF			DATE 20	. LOCATION — 0	aty or To	own, State MD ANDALLSTOWN,		
	21. SIGNATURE OF FUNERAL SERVICE LICE	NSBI			ID ADDRESS OF FA		10 100		ANDADISTONN,		
	Goel 1	Lewi	'S		EVINSON REISTERS			MOR	E, MD 21215		
	23. PART I. Enter this diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory strest, enterty and proving the interval Between Onset and Death disease or condition resulting in death) 3. Due to (or as a conscouence of):										
N	Sequentially list conditions b.										
CERTIFICATION	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury										
ERTIF	that initiated events resulting in deeth) LAST d.	DUE TO (OR AS A CO	INSECUENCE OF):								
AL	PART II. Other significant conditions	Q . 11/		the underlying	g ceuse given in		S AN AUTOPSY RFORMED?	24b	. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO		
Old		Fauk yso				t 🗆 YI	ES 2 NO		COMPLETION OF CAUSE OF DEATH?		
M	DID TOP A CCO LICE CONTR	Domen +1							1 YES 2 NO		
AN	DID TOBACCO USE CONTR		PLACE OF DEATH	Check only one	UNCERTAI	и Ц					
PHYSICIAN: MEDIC	EXAMINER?	HOSPITAL: 1 Inpatient 2 ER/Outpatie		OTHER.	e 5 🗆 Residence	e Char (Passis					
HX	27. MANNER OF DEATH	26a. DATE OF INJURY	26b. TIME	OF 28c, INJ	URY AT	28d. DESCRIBE H		URED			
ВУ Р	t Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	INJUI	M 1 1	PRK? YES 2 NO						
ED	3 Suicide 6 Could not be datarmined City or Town, State) 4 Hemicide Hemicide 1288. PLACE OF INJURY — At home, farm, street, factory, office City or Town, State)							Route Number,			
COMPLET	one)	IAN: To the best of my knowledge									
00	2 MEDICAL EXAMINER	: On the beals of exemination as	nd/or Investigation,	, in my opinion, d	eath occured at the	time, data and place	ca, and due to the	cause(a) and manner as stated.		
296. SIGNATURE IND TITLE OF CERTIFUR 29 LICENSE NUMBER							- N	SIGNED	(Month, Day, Year)		
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type Print)											
Tru H JA tel Cape king MD 5310 Old (00 1+Road Suite 28) Rundallstrum, MD 31. DATE FILED (North, Day, 1001) 102. REGISTRAP'S SIGNATURE DE C1 91995 Min D'Audion Landell							1021133				
	DECT 3/3/3/2	The Muderka	Mall								

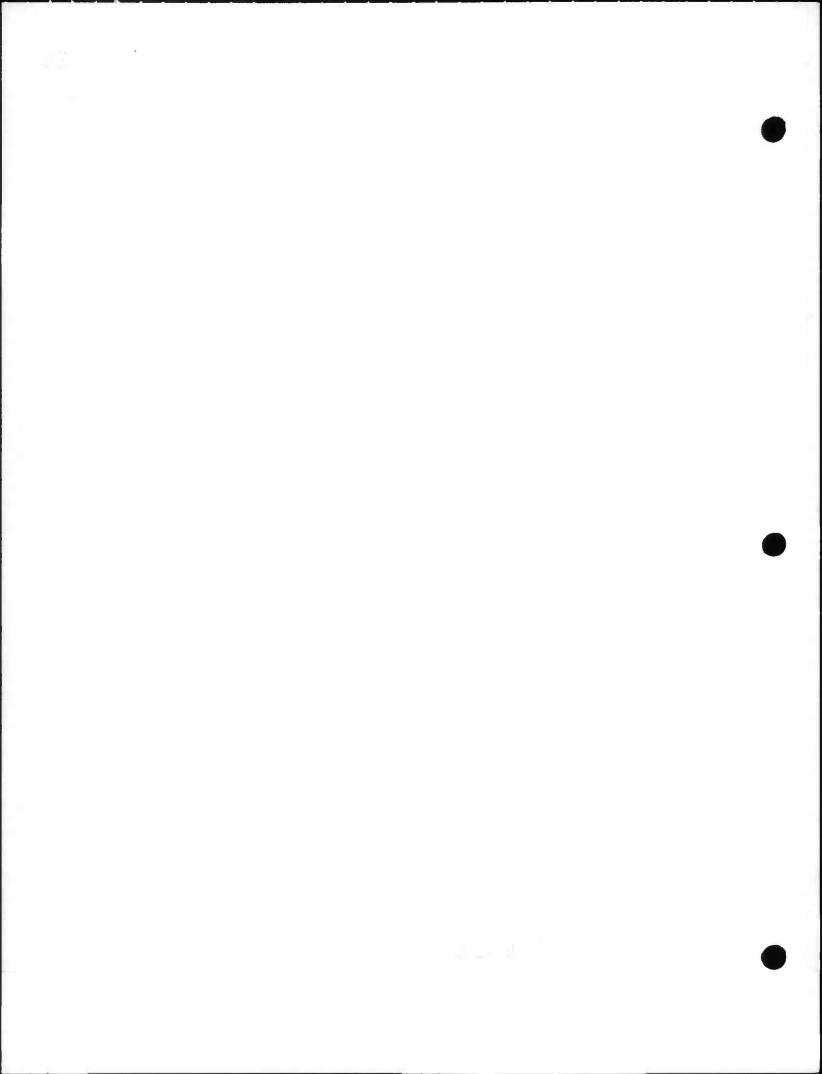


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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 nours after death. Page 8 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be mentited at never.
--

	1 - FOR STATE REGISTRAR	STATE OF MARYLAND	/ DEPARTM			MENTAL HYGIEN				
- 6	1. DECEDENT'S NAME (First, Middle, Last) Ruth R. Gerbi					2. DATE OF DEATH MONTH 12 1		3. TIME OF DEATH 11:05 A M		
- 6	4. SOCIAL SECURITY NUMBER 214-40-5331 1 [SEX 6. AGE (In yrs. 88		UNDER 1 YEAR	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) 07-07-0	8. BIRT	HPLACE (State or Foreign		
TOR	96. FACILITY NAME (If not institution, give street of BROADMEAD RESIDENCE OF DECEDENT	and number)	98		CKEYSV		9c. COUNTY OF			
DIRECTOR	10a. STATE 10b. COUNTY	LTIMORE	10c. CITY, TO	OWN OR LOCAT	CKEYSV:		10d. INSIDE CITY LIMITS? 1 YES 2XXNO			
FUNERAL	13801 YORK ROA			101. ZIP CODE 109. CITIZEN OF WHAT COUNTRY U.S.A.						
B	1 Never Married 2 Married	WAS DECEDENT EVER IN U.S. FORCES? 1 Tyes 2X IF YES, GIVE WAR OR DATES	ARMED X40	If yes, spe	ENDENT OF HISPAI city Cuban, Mexica XIXNO Specifi	NIC ORIGIN? (Specify Ye in, Puerto Rican, etc.) y:	Spe	CE — American Indian, ck, White, etc. c/ly: HITE		
COMPLETED		ON pleted) 16a. pleted) TEAR	DECEDENT'S USE (Give kind of work life. Do NOT use re TEAC	done during mo: tired.)	UPATION 16b. KIND OF BUSINESS/INDUSTRY 16p most of working					
O	17. FATHER'S NAME (First, Middle, Lest)	DAK								
BE C		SSELL			SARA	AH HARR	rs .			
5	196. INFORMANT'S NAME (Type/Print) DAVID C. HAILE					NUE, TOWS				
	20a METHOD OF DISPOSITION	20b.PLAC	E AND DATE OF D	ISPOSITION (Na			CATION — City or			
	4 Donation 5 Other (Specify)	LOU	DON PA	RK CE			ALTO.,M	D.,21229		
	· R. H. Let			HE 4905	YORK I	JENKINS ROAD, BALT	IMORE,	SONS MD.21212		
	23. PART I. Enter the diseasea, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or reepiratory strest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in deeth) a. PNEMMONIA Approximate interval Between Onset and Death									
CERTIFICATION	Sequentially list conditions, if sny, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):									
H	resulting in death) LAST									
PHYSICIAN: MEDICAL C	PART II. Other algnificant conditions contributing to deeth but not resulting in the underlying ceuse given in Part I. AULTI - NEAR CT DEMENTIA 1 24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 DNO OF D									
AN	25. WAS CASE REFERRED TO MEDICAL	LSUPHAG	1713	/26. PL	ACE OF DEATH (Ch	eck only one)				
Sic		OSPITAL: Inpatient 2 ER/Outpatient		гней:		8 Other (Specify)				
	27. MANNER OF DEATH 1 ☑ Naturat 5 ☐ Pending	28s. DATE OF INJURY (Month, Day, Year)	28b. TIME OF	WO	IRY AT RK? ES 2 NO	28d. DESCRIBE HOW	NJURY OCCURED			
TED BY	2 Accident Investigation 3 Suicide 8 Could not be determined	28e. PLACE OF INJURY — At building, etc. (Specify)	home, lerm, stree			281. LOCATION (Street and Number or Rural Route Number, City or Town, State)				
COMPLETED		To the best of my knowledge, in the basis of examination and/o						(s) and manner so stated.		
TO BE C	296, SIGNATURE AND TITLE OF CERTIFIER 30. NAME AND ADDRESS OF PERSON WHO CO	rholli		D38	D38392 ≥ 12/15/95					
	BARBARA CA	RROLL, P 32. REGISTRAR'S SIGNATURE	1D. 1	3801	YOR	K RD,	Cock	EYSVILLE		
1	DEOT 3 1995 41	a alterestantiant	H							





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 95 382

						Cer	tificate of	Death		R	eg. No.			tion .
	4.5		1. Decedant's Nama (First, Midd	le, Last)						2. Data of Dea	lh	V	3. Tim	a of Deeth
	Physici /Medi			Charles	Glen	ı				Dec	15, 19	Year 95	5	:30 A.M
}	Examir		4a. Fecility Neme (If not institutio	n, give streat and numbar)				4b. City, To	own, or Lo	cation of Death	4c. County	-		
1			2544 W. Coldsp	oring Lane					imor		N'	A		
	Funeral Director		5. Social Sacurity Number 422-12-5471	6. Sex 7. Ag	a (In yrs. lest bir	thday) Yrs.	Months Deys		Min.	8. Dete of Birth (Month, Dey July 8,		9. Birthp Cour	placa (Sta	te or Foreign
	and		Usuei Residence of Decedent 10e. Stete 10b. County		10c. City, Tow	n or Loc	cation					1	0d. Inside	a City Limits
	Meny	tor	Md N/A Baltimore											as 2 No
	h the	rec	10e. Street end Number				10f. Zip Code			1	Og. Citizen of V	Vhat Cour	niry?	
	th with	alD	2544 W. Cold	spring Lane			2121	5			US	Α		
21215-0020	d 2 should be filed within 72 hours effer deeth with the Maryland th and Mental Hygiene. The marked other than "natural", or frems 23s or 28s-f show traumatic event, the Medical Examinat must be notified at	by Funeral Director	11. Meritai Stalus 1 □ Navar Marriad 2⊠ Mar 3 □ Widowed 4 □ Divorced	If Yes. Give			Vas Decedent of Yas, specify Cul			ecify Yes or No- Rican, atc.)		e - Amario ik, Whila, : B1		
2-0	72 ho	peted	15. Deceden	nt's Education st grade completed)	16a.	Deced	enl's Usuei Occu	ipalion	et of undi		16b. Kind of Bu	isiness/în	dustry	
21	ithin	Completed	Elementery/Secondery (0-12)	College (1-4or 5	+)	lifa. D	kind of work done O NOT use retin	ed)	SI OI WOIKII	ng .				
121	led w lygier her th		8th grade	N/A	1	abo	rer				Bethle		Stee	
Maryland	tai H d off	Be	17. Father's Name (First, Middla, Luther Glen	Last)						(First, Middle,		10)		
Ž	d Me	2	19a. informant's Neme/Reletions	this Charles Colon	401	A 4 - 77	A 11 (0			Lou Sut		0	0.41	
Ma	d 2 s th an 7 ls r traus			snip (19pe, Print)			g Address (Stree							
e,	ges 1 and t of Health If Rem 27 or other to		Flora Mae Glen 20a. Method of Disposition		20b. Piece of	Dispos	N. Colds sition (Neme of atory or other pla	pring	Lane	Dele Balti	more, 1	Ad_21 City or To	215 wn, Stete	
JOL	Peges 1 and 2 nent of Health e set: If Item 27 is ury or other tra		1 ☐ Buriel 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		Collingia	y, crem	Memoria	800)	i					
Baltimore,	当者を正		21. Simulation Funeral Servica		Mare	22.	Name and Addr	ass of Facili	ity	21895	Raleigh	1, N.	U.	
Ö	Depa Impo		M W.	- 1 7	2116)	March F,	/H We	st					
	Physician /Medical		23a. Part 1. Enter the divises, or shock, or heart failute. List	complications that caused only one cause on each life	the death. Do ne.	not ente		Ping, such as			ast,			Between nd Death
H	Examiner	Ų.	disaasa or condition resulting in deeth)	0. 1100	Due to (or es a	consequ		jour		-φ		U	Kor	- Sylan
_	nsit	Examiner		b			3							
ć	eath certificate be executed ethending physician and for use as the burial-transit		Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or injury		Due to (or es e	consequ	uence of):							
68760,	ite be ysicle	edicai	Cause (Disease or injury theil initialed events theil initialed events trasulting in death) Last Due to (or as a consequence of):											
39 ×	ing ph	Med	rasulting in Coatti) Last	L.								į		
Вох	ath ce ttend	ian		G								i		
0	the death y the etter sched for u	Physician/	Pert ii. Other significant condition	ons contributing to death be	it not resulting in	the un	derlying cause g	iven in Pert	1.	23b. Dld to	obacco use co	ntribute to	the cau	e of death?
σ.	es thet the de igned by the e be detached i		(may	arter d	colar	2				1 🗆 Y	es 2€No	3 Pro	bably 4	Unknown
Records,	aw requires been so should	Completed by	anemia	Con	nie	d	islan	•		24e. Wes e perfor		av	ere autop ailable pri mpletion death?	
	0 - 5	Com								1 🗆 Y	es 20No	10	∃Yas :	2 No
of Vital	delan: The certificate rector, pag	Be (25. Wes casa referred to medica axaminer?	A APPLICATION				28. Plece	e of Deeth	(Check only or	ne)			
of V	5 00	70	10 Tes 2 No 9	Hospita 1 ☐ Inpatie		tpetient	3□ DOA O	ther: 4 🗆 No	ursing Hor	ne Besid	ence 6 Oth	er (Specif	(y)	
ono	Ing After	tlon:	27. Menner of Deeth Naturel 5 Pendir			rime of njury	28c. Inju Wi			28d. Describe h	ow injury occur	ed		
Division	Ital or Attending irs efter death. al Director: After ied in by the fune	Certification:	2 Accident 3 Suicide 4 Homicide Investigation 6 Could not be determined 28e. Plece of injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Ru City or Town, State)								er or Run	al Route A	'umber,	
	To the Hospital or within 24 hours effer To the Funeral Dircompletely filled in	edical	29e. Certifier (Check only 2 Medical	ng Physician: To the best of Examiner: On the basis of and manner sta	f my knowledge examinetion en	, deeth d/or inv	occurred at the t estigetion, in my	lme, dete en opinion, des	nd piece, e eth occurre	and due to the c ad at the time, d	euse(s) end me ete and piece,	nner es s and due to	tated. the caus	ie(s)
	To the within 2 To the comple	Me	29b. Signalus and title of certifie		10.1	12.	9c. Licer	se number		2	9d. Dete signe	d (Month,	Dey, Yea	n
	FSFO		1 Oleman	more of	Buc	can	1	1819	77		1Mi	57	95	
	6+ 1		30. Name and eddress of person	who completed cause of di	and (item 23e)	Type, F	Print) 2360) W	SOPI	A RC	· LUT	1127	VILL	is my
	Sta	te	31. Dete filed (Month, Dey, Year)	32. Registre	r's Signeture		, ,					21	09	3

Section was to APP at 1996

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

IR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within Z4 hours after death, Page 6 may be retained by the hospital or attending physician.	INSECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should must after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be neitfled at once.
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TO BE COMPLETED BY FUNERAL DIRECTOR

FOR			44714 -117							95	38228
STATE REGISTRAR		STATE OF I				OF DEATH		ITAL HYGIEN REG. NO			
1. DECEDENT'S NAME (First	t, Middle, Lest)							DATE OF OEATH	AY	YEAR	3. TIME OF DEATN
BENTON	NEAL	HAI	RRIS,						16.1		6:40 A
4. SOCIAL SECURITY NUMI		5. SEX	6. AGE (In yrs. la		IF UNDER 1 YE			MATE OF BIRTH Month, Day, Year)		Countr	PLACE (State or Foreign
003-09-5340		1 M 2 □ F	75	YRS.	and this of	NOONS .	J	an. 6, 1	.919	Geoi	rgia
9e. FACILITY NAME (If not in	nstitution, give si	treet end number)			9b. CITY, TO	WN OR LOCATION	OF DEATN			NTY OF D	EATH
THE JOHNS	HOPKIN	NS HOSPIT	AL		BALT	IMORE CI	TY		N/A	1	
10e. STATE	10b. COUNTY	1		10c. CIT	Y, TOWN OR L	OCATION					10d. INSIDE CITY
Maryland	Bal	ltimore		Bal	ltimor	e					LIMITS?
10e. STREET AND NUMBER						10f. ZIP CODE			10g. CIT	IZEN OF W	HAT COUNTRY?
6002 Overlo	ook Pla	ace				21210			U.	S.A.	
11. MARITAL STATUS		12. WAS DECEDEN			13. WAS	DECENDENT OF	HISPANIC O	RIGIN? (Specify Ye		14. RACE	— American Indien,
1 Never Merried 2 2 3 Wildowed 4 Dive		FORCES? 1	X YES 2 1	NO	1 [e, specify Cuben, I YES 2 XNO	Hexicen, Pu Specify:	erto Rican, etc.)		Speci	white, etc. White
	CEDENT'S EDUC		16a. D	ECEDENT'S	USUAL OCCU	JPATION ng most of working		16b. KIND OF BU	SINESS/IN	DUSTRY	
Elementary/Secondary (0-12)	College (1-4 or 5	+)	ii. Do NOT u	se retired.)			73.7			
	***	years	M	anufa	acture:	r		Plasti	cs		
17. FATHER'S NAME (First, A								First, Middle, Melder			
Benton Nea		is, Sr.						Gwen Mo			
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town. State, Zip Code) Mary Norman Tomlin Harris 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town. State, Zip Code) 6002 Overlook Place Baltimore, MD 21210											
		in Harris	-				e Bal				
20e. METHOD OF DISPOSIT 1 Burlet 2 Cremett 4 Donation 5 Othe	on 3 🗆 Rem r (Specify)				of disposition of the Crem	atory	Dec.	18 Bal	timor		wn, state laryland
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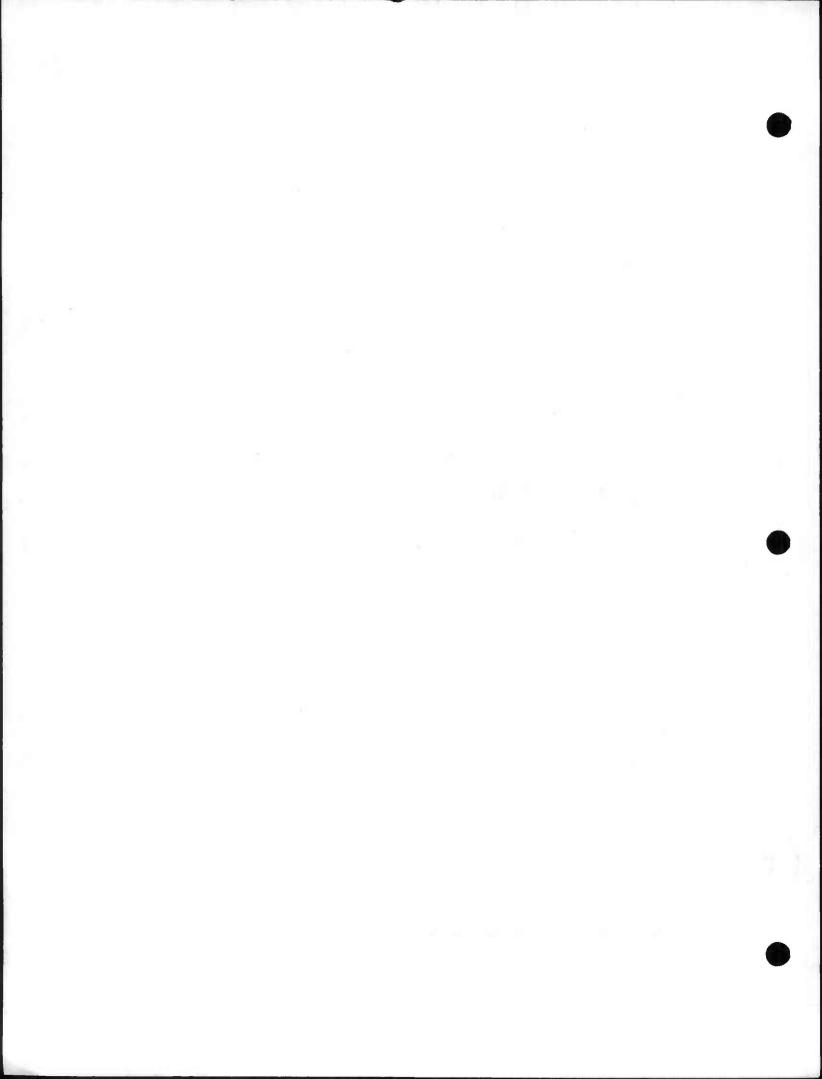
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30. NAME AND ADDRESS OF PERSON WNO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

CHAN

M. O. GUO NORTH

2287-810



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours aher death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If them 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

ITEMS: 19a,20b, PER F.H. FILM G-730 12/19/95 t.t

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22. NAME AND ADDRESS OF PRICLITY SOL LEVELYSON & BROS., INC. 6010 REISTERSTOWN ROAD BALTIMORE, MD 21215 APPRATT I. Enter the diseases, or complisasyers that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interevt Between considering the condition are sulfing in death). List spirity one cause on each line. IMMEDIATE CAUSE (Final disease or condition) resulting in death) Sequentially list conditions, if any, leading to immediate cause finite numerical cause	1 XBuriel 2 Cremation 3 Rem		cemetery, crematory or o	ther place)	12/	15/95					
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	FOR STATE REGISTRAR	STATE OF MARYLAND / DEPARTMENT OF HEALTH AND CERTIFICATE OF DEATH	MENTAL HYGIENE REG. NO.
4	1. DECEDENT'S NAME (First, Middle, Last)		2. DATE OF DEATH MONTH DAY

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23. NAME AND ADDRESS OF FACINTY ROAD BALTIMORE, MD SOL LEVINSON & BROS., INC. 23. PART Emit the disease, or complications this, caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interpretations, or heart fellure. Lief only one cause on each line. 14. IMMEDIATE CAUSE (Final disease or conditions, interpretations) in the cause of conditions, in the cause of conditions, in the cause of conditions, in the cause of conditions, in the cause of conditions, in the cause of conditions, in the cause of conditions, in the cause of conditions, in the cause of conditions, in the cause of conditions, in the cause of conditions, in the cause of conditions, in the cause of conditions, in the cause of conditions, in the cause of conditions of cause or conditions of cause or conditions on the cause of conditions or cause or conditions or cause or conditions or cause or conditions or cause or conditions or cause or conditions or cause or conditions or cause or conditions or cause or conditions or cause or conditions or cause or conditions or cause or conditions or cause or conditions or cause or conditions or cause or conditions or cause or conditions or cause or conditions or cause or cause or conditions or cause or conditions or cause of cause or cause of cause or		1 Burial 2 X Crematic	on 3 🗆 Ramo	oval from State						-					
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2 Accident Investigation Suicide Society See. PLACE OF INJURY — At home, ferm, street, lectory, office 281. LOCATION (Street and Number or Rural Route Number of Rur	¥	25. WAS CASE REFERRED T							0.11						
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3 Suicide 8 Could not be determined building, etc. (Specify) 29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the best of my knowledge, death occurred at the time, date and piece, and due to the ceuse(e) and menner ee stated. 29b. SIGNATURE AND TIME OF CERTIFIED PHYSICIAN: To the best of examination, entire sine satisfation, in my opinion, death occurred at the time, date and piece, and due to the ceuse(e) and menner ee stated. 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Dev. 10 15 16 2 10 15 15 16 2 10 15 16 16 16 16 16 16 16 16 16 16 16 16 16				(MOTRIE,	Day, rear)	ING				□ NO					
296. SIGNATURE AND THE COMPLETE CAUSE OF DEATH (ITEM 27) (Typo, Print) 296. LICENSE NUMBER 296. LICENSE NUMBER 296. LICENSE NUMBER 297. D 15462 296. LICENSE NUMBER 297. (Typo, Print)		3 Suicide 8		28e. PLACE :	OF INJURY — At ho	me, ferm, s	street, lectory	, office			28f. LOCATION (Street end Number or Rural Route Number, City or Town State)				loute Number,
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P 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)		206 SIGNATURE AND STUDE OF CENTER AND STUDE OF													
MIGUEL KARACUSCHANSKY HD. 300 E. 33nd St BALTO 2		28d. DATE SIGNED (Month, Day 1007) 28d. DATE SIGNED (Month, Day 1007) 28d. DATE SIGNED (Month, Day 1007) 28d. DATE SIGNED (Month, Day 1007) 28d. DATE SIGNED (Month, Day 1007)													
		MIGUEL	KAR	ACUSC	HANSK.	Y	ري.	30	0 6	. 3	3nd	24	B	A LV	0 21218
31. DATE FILED (Month, Day, Year) DEC 1 91995 32 REGISTRAR'S SIGNATURE DEC 1 91995															

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with

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FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 -**CERTIFICATE OF DEATH** REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH Dec. 16 1995 AR Lillian Patricia Harmon 04:00 Am 4. SOCIAL SECURITY NUMBER 7. DATE OF BIRTH Sept 23, 1941 B. BIRTHPLACE (State or For Country) Maryland 5 SEY 6. AGE (In yrs. last birthday) 8. BIRTHPLACE (State or Foreign IF UNDER I YEAR IF UNDER 24 HRS. 220-38-6700 DAYS 54 HOURS 1 - M 2 X F Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH University of Maryland Hospita Baltimore City Baltimore DIRECTOR RESIDENCE OF DECEDENT Maryland Baltimore 10d. INSIDE CITY Baltimore City 1 YES 2 XNO permit. 10g. CITIZEN OF WHAT COUNTRY? FUNERAL 5922 Smith Avenue 21209 use as the burial-transit 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2X NO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No-14. RACE — American Indian, Black, White, etc. 1 Never Merried 2 Merried If yes, specify Cuben, Mexican, Puerto Rican, etc.)

1 YES 2 XNO Specify: IF YES, GIVE WAR OR DATES Specify: White BY 3 Widowed 4 Divorced 15. DECEDENT'S EDUCATION 16e. DECEDENT'S USUAL OCCUPATION 16h, KIND OF BUSINESS/INDUSTRY (Give kind of work done ife. Do NOT use retired.) ET è Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker COMPL Own Home page 5 should be detached notified at once. 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Melden Surneme)
Lillian K. Ruff Thomas B. Hardy 190. INFORMANT'S NAME (Type/Print)
Thomas R. Harmon Sr. 19b. MAILING ADDRESS (Street end Number or Rural Route Number, City or Town, State, Zip Code) Smith Avenue, Baltimore, Maryland 5922 pe 20e METHOD OF DISPOSITION
1 A Burlel 2 Cremetion 3 Removal from State
4 Donetion 5 Other (Specify) DATE 20c. LOCATION -- City or Town, State 20b. PLACE AND DATE OF DISPOSITION /Name of must funeral director, "Druta"Riage Cemetery 12/19 Pikesville, MD 22. NAME AND ADDRESS OF FACILITY
Burgee-Henss Funeral Home 21211
3631 Falls Road, Baltimore, Maryland examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE racin Henss in by the medical 23. PART I. Enter the disesses, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory strest, shock, or hasrt failure. List only one cause on eech line 6 filled IMMEDIATE CAUSE (Final Onset and Death 21 days the cremation, disease or condition MULTIMITEM ORGAN FAILURE completely resulting in desth) traumatic event, DUE TO (OR AS A CONSEQUENCE OF) 21 days bunial, SEPSIS CERTIFICATION and Sequantially list conditions, if any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF): prior to the attending physician I Mental Hygiene prior to cause. Entar UNDERLYING CAUSE (Disease or Injury other DUE TO (OR AS A CONSEQUENCE OF) that initiated events resulting in death) LAST 0 Injury, PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE 24a. WAS AN AUTOPSY PERFORMED? signed by the shows any 1 TYES 2 NO DF DEATH? 1 TES 2 NO bept. of H DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: the State Dr. 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) OTHER: 1 YES 2 NO Inpatient 2 - ER/Outpatient 3 - DOA 4 Nursing Home 5 Reeldence 8 Other (Specify) 27. MANNER OF DEATH 26c. INJURY AT WORK? 26e. DATE OF INJURY 28d. DESCRIBE HOW INJURY OCCURED 28b. TIME OF INJURY this c marked, 1 Natural 5 Pending Investigation м 1 YES 2 ND BΥ 2 Accident After 28e. PLACE OF INJURY — At home, ferm, street, factory, office building, etc. (Specify) 3 Suicide 261. LOCATION (Street end Number or Rural Route Number, City or Town, State) 6 Could not be determined 99 DIRECTOR: A hours after of Item 28 Is COMPLETED 4 Homicide It Item 29e. CERTIFIER (Check only CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) end menner as stated. FUNERAL C 2 MEDICAL EXAMINER: On the beele of examination end/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(e) and manner se stated, MPORTANT: 29b. SIGNATURE AND TITLE OF CONTIFIER THE F 29c LICENSE NUMBER 29d, DATE SIGNED (Month, Day, Year, BE AUG126438AJZZY1 tomball. 5 5 3 WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) J. DELPIZED Bathmere 22 5 Greene 32 FEGIS PAPES S-NAMES

Please Type or Print In Black Indelible Ink. Assure All Copies Are Leg

Items1,17,18 12-19-95

1. Decedant's Name (First, Middle, Last)

State of Maryland / Department of Health and Mental Hygiene

IDIE	A	2	3	2
	U	C	V	(mar

W.H.Per F/H Physician /Medica

Examine

Certificate of Death

2. Data of Death 3. Time of Death Humphries Month Day Year P.M

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours effer death with the Meryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 23s or 28a-f show any injury or other traumatic event, the Medical Examinal must be notified at ence.

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

Be Completed by Physician/Medical Examiner sician and bunal-transit To the Mospital or Attending Physician: The lew requires that the death certificate be executed within M hours effer death.

To the Funeral Director: After this certificate has been signed by the attending physician and attending physician for use as the buna filled in by the funerel director, Certification: To # Hours efter death.

Division of Vital Records, P.O. Box 68760,

an al	SIDNEY	ALAI	V			HIM	PHREY		DEC	8	95	5:33 P.I		
er	4a. Facility Nama (If not institution, 533 E.41 stre	4b. City, Town, or Location of Death BALTIMORE 4c. County of De												
	5. Social Sacurity Number 231-05-3124	birthday)_ Yrs.	If Undar Months	1 Yaar Days	If Under 2 Hours		8. Date of Bird Month Da JUN 9,	1919	9. Birthpiace (State or Fore VIRGINIA					
Be Completed by Funeral Director	Usual Residence of Decedent 10a. Stata 10b. County MD	10c. City, To	Dc. City, Town or Location BALTIMORE							10d. inside City Limits 1 △ Yas 2 □ No				
	10e. Street and Number 533 E. 41	st STREE	Γ		10f. Zip		21218			10g. Citizen of What Country? UNITED STATES				
	11. Maritai Status 1 Never Married 2 Marrie XX Widowed 4 Divorced	Ever in U,S. ? (No		13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2★★No Specify: 14. Race - American Indian, Black, White, etc. Specify: BLACK										
ompleted	15. Decadent's (Specify only highest Elementary/Secondery (0-12)	5+)	(Give k	Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) PAINTER GOLD SICKER CO.										
To Be Co	17. Father's Name (First, Middle, Le	harles					18. Mother	s Name	(First, Middle,	First, Middle, Maiden Sumame) ES ANNA NORRIS				
-	19e. Informant's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, 533 E. 41 st STREET, BALTIMORI											^{de)} 21218		
	20a. Method of Disposition 20b. Place of Disposition (Name of cemetary, crematory or other place) 4 Donation 7 Other (Specify) 20b. Place of Disposition (Name of cemetary, crematory or other place) WESTERN S TAR CEM. 12-18 CATONSVILLE, MD													
	21. Signature of Pineral Servica Lie 23a Part Enterine disease, or co	E 41	d the death. D	with the window	М. С.	. MA	SS of Facility RCH FH			NORTH		proximete		
	Immediate Cause (Finel disease or condition resulting in death)	Arterio										erval Between iset and Death		
Iner	resulting in dealing		Due to (or as e consequence of):											
Exam	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying	b	Due to (or as	a consequ	enca of):						1			
sician/Medical Examiner	Cause (Disease or Injury that inflated events Dua to (or as a consequence of):													
ysician	Part ii. Other significant conditions	a contributing to death t	out not resulting	en in Part I.		23b. Did 1	obacco use co	ntribute to the	cause of death?					
by Ph									10	Yes 2□ No	3 Probabl	y 4 Minknown		
Completed									perto	an autopsy med? ECTION	availat	autopsy findings ble prior to etion of cause th?		
Col	DE Miss assauratement to mortical									es 212 No	1 □ Y€	es 2 No		
To Be	25. Was case referred to medical examiner? 1127 Yes 2 No	Hospital:	ent 2□ER/	Outpatient	3□ DO	Oth			(Check only o		at (Specify)			
rtification: T	27. Manner of Death 1 Natural 5 Pending 2 Accident investigat	28a. Data of Inju (Month, Da		b. Time of injury		8c. injur		28	me 5XX esidence 8 Other (Specify) 28d. Describe how injury occurred					
rIIIC	3 Suicida 6 Could not determine	200. Placa of in	jury - At home, c. (Specify)	, office		28	of Location (5	ocation (Street and Number or Rural Route Number, City or Town, Stete)						

31. Date filed (Month State Registrar

Medical

29a. Certifier

29b. Signature ap

of death (Item 23a) (Type, Print) Dixon M.D.

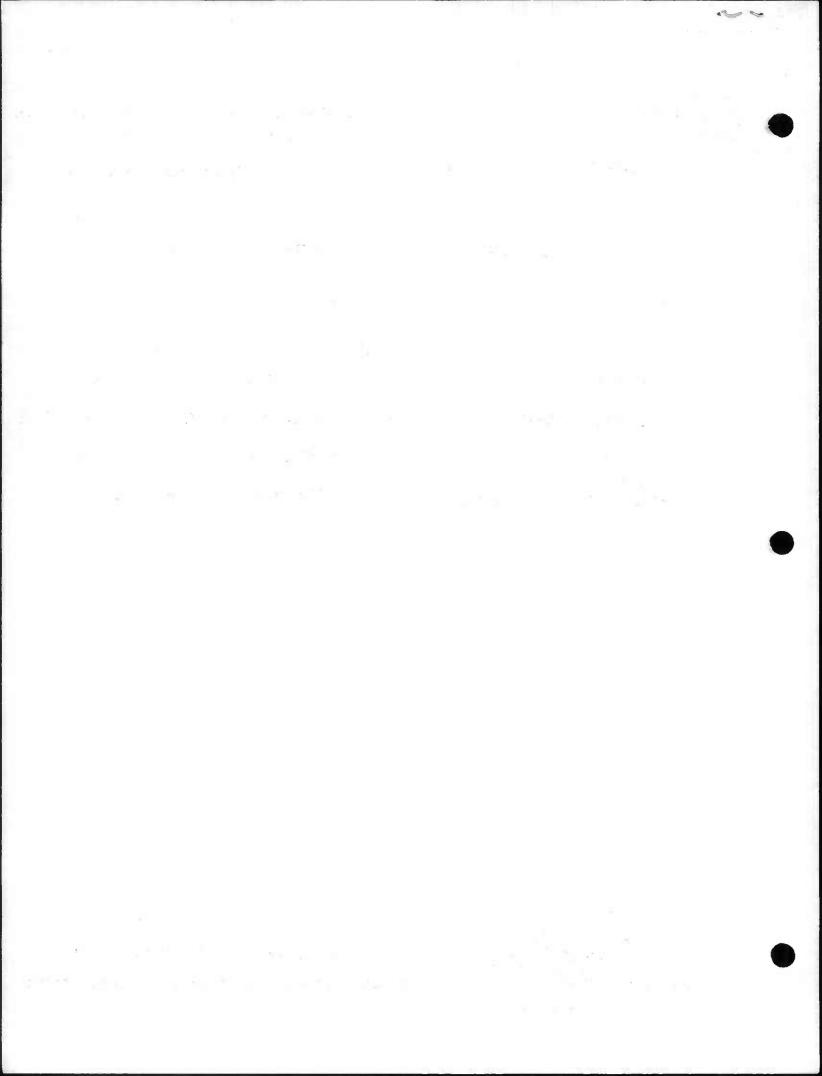
1 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) end the ime as access.

2 Medicat Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and dua to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

O.C.M.E.

DECEMBER 9,1995

111 Penn Street, Baltimore, Maryland 21201



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

				Otate of W	arylari	Certific		Death		Reg. No.	5 3	1823	3
		7	1. Decedent's Name (First, Middle, La	ast)		2. Dete of De Month	eeth		3. Time of [Death			
	Physici /Medi		BERNARO H.	HYLLS	TAD				D250	Day	995	3A1	7.
	Examir		4a. Facility Name (If not institution, gir	1				4b. City, Town, or L					
V				CAO	na /haa	In an Ariesta stand	nder 1 Year	If Under 24 Hrs.	8. Date of Bir (Month, Da	ARFO	RO	-	
	Funeral Director			ASS N OF F	S I	last birthday) If U Yrs. Mor		Hours Min.	iace (State or	Foreign			
	yland		10a. State 10b. County		10c. Cit	y, Town or Location					1	0d. Inside City	y Limits
	filed within 72 hours efter death with the Maryland thygiene. ther than "naturet", or items 23a or 28a-f show int, the Medical Examinet must be notified at	ctor	MARYLAND HARF	ORD		STRUET	-					1 Tes	20 No
	or 28	Directo	10e. Street end Number	\		10	. Zip Code			10g. Citizen of	What Cour	itry?	
	ath w		3805 ADY 19	CAO			21	154		V.	S.A.		
	ler dea	Funeral	11. Marital Status 1 Never Married Married	12. Wes Decedent Armed Forces?	Ever in U	S. 13. Wes D	ecedent of I specify Cub	Hispanic Origin? (S) an, Mexican, Puerte	pecify Yes or No Pican, etc.)	- 14. Ra Bia	ce - Americ ack, White,		
020	et, or items	by F	3 Widowed 4 Divorced	if Yes, Give Year or Detes:		1 Y	es 28 No	Specify:		Speci			
21215-0020	"naturet",		15. Decedent's E	ducetion	W- W_		Usuel Occur	pation		18b. Kind of E		dustry	
21	d within 72 ha	Completed	(Specify only highest grant Elementary/Secondary (0-12)	ade completed) College (1-4or :	5+)	life. DO NO	of work done OT use retire	pation during most of world)	King				
	ygien yer th	Con	13782	byrs.		CAPT	AIR			U.S. RAVY			
Maryland	a la b	Be	17. Father's Name (First, Middle, Last					18. Mother's Nam	ne (First, Middle,				
Z	d 2 should th end Men 7 Is marks traumatic	2	19a. Informant's Name/Reletionship		11221		trace (Street	51,2AC	H/3E	OAU		Cadal	
	BEND		WILDE J. HYW	00.22		2205 (200	CAO ST	OST	DORY	A AA	21151	4
re,	f Health tem 27		20a. Method of Disposition	22010	20b. P	Place of Disposition emetery, crematory	(Neme of		Date	20c. Location	- City or To		
mo	Pages ent of nt: if it iry or o		Burial 2 ☐ Cremetion 3 ☐ 4 ☐ Donetion 5 ☐ Other (Special		0	UNIAIN C	HO: SI		1992	FAULSTO	1 De	RYLAN	^
Baltimore,	pemit. Pages 1 e Department of Hea Important: if item eny injury or othe once.		21. Signature of Euneral Service Liga	nsee	1. 10		e end Addre	ess of Fecility	10001	- B21 P	Sil	P.A.	
m	82 2 2 8		Mark to	51 0 6.1	& FOR	LHIZA	100	0-1/AN	0201				
			23a. Part1. Enter the diseese, or com shock, or heart failure. List only	iplications that caused one cause on each li	d the death	h. Do not enter the	mode of dyle	ng, such as cerdiac	or respiratory a	rrest,		Approximate tntervai Betw	
	Physician /Medical				,							Onset and De	
1	Examiner		Immediate Cause (Final disease or condition resulting in death)	a	Ly	mpho	San	coma			1		
		Jer			Due to (6	r as a consequence	of):						
	secuted and Ftransit	Examiner	Sequentially list conditions	b. — Due to (or as a consequence of):									
00	be executed Ician and burial-transit	Ex	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying				,						
68760,	cete be e physician the buris	edicai	Cause (Disease or injury that initiated events resulting in death) Last	C	Due to (or	r es e consequence	of):						
	requiras that the death certificete be executed een signed by the ettending physician and hould be detached for use as the burial-transit			d									
Box	etter for u	clar	Dont II. Other plantitions and distance			Marie Control of the Control			1 001 Bt 4	Ne Incessor I			
P.O.	that the de led by the detached	Physician/N	Part ii. Other significant conditions of	contributing to death b	ut not resi	uiting in the underly	ng ceuse gr	ven in Pert I.			co use contribute to the cause of death? 2 No 3 Probably 4 Unknown		
	gned o	ру Р	-	1 □ Yes 2 ☑ No				AU., 400	MIKIOWII				
Vital Records,	w requires that been signed I should be det	Completed by				24a. Was an autopsy performed? 24b. Were autopsy aveilable prior					ndings		
ec	- LJ (0)	npie									of	mpletion of ca death?	use
E									10	Yes 🔀 No	10	Yes 20 N	No
Vita	Physician: The this certificate ral director, page	Be	25. Was cese referred to medicei examiner?	Hospital:			Ott	28. Place of Dea					
o to	Phys this ral di	2	1 ☐ Yes 2 ☑ No 27. Manner of Death	1 L Inpatie		ER/Outpatient 3E 28b. Time of	ואטם נ		ome 524 Resident			0	
on	Attending For death. Settor: After by the funer	ation	1 Netural 5 ☐ Pending 2 ☐ Accident investigatio	28a. Date of Inju (Month, Da	y Year)	tnjury M	28c. Injui Wor	rk? Yes 2 □ No					
Division	er death. ector: Al by the fu	tifica	3 Suicide 8 Could not be determined	≥86. Place of Inj	28f. Location (Street and Number or Rural Route Number, City or Town, Stete)								
- in in in in in in in in in in in in in									Only or You	VII, 3(6(6)			
29a. Certifier (Check only one) 29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the course of examination and/or investigation, in my opinion, death occurred at the time, date and manner stated.										cause(s) and m	anner as s	ated. the cause(s)	-115
and manner stated. and manner stated. 29c. License number										29d. Dete aign			
	⊬≯≓ŏ	A Common de la Com											
	1	-	30. Name and address of person who	***	3			401ew		rano	ERIL	1795	, ,
	(4)		LAPRY W	ATERBU	RY,	40 3+	1 Ba	your	bred.	cnhe	, 13	sel.	cd
1	Sta Registr		31. Date filed (Month, Day, Year) 9	1995 32. Registr	ar's Signal	teor Reclass							

TO THE HOSPITAL, OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTION: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If them 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TTEM: 19a, PER F'.H. F'ILM G-730 12/19/95 t.t

1 - STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REG. NO.

_							D		HEG. NO.					
į	1. DECEDENT'S NAME (First, Middle, Last)								2. DATE OF DEATH MONTH DA	3. TIME OF OEATH				
	Catherine			HARMAN					December 16,1995 4:15				рм	
1	4. SOCIAL SECURITY NUMBER	6. AGE (In yrs. la	st birthday)	IF UNDER	1 YEAR				8. DIRTHPLACE (State or Foreign					
	220-24-1621	1 □ M 2 □ ₹	67	67 YRS. MONTHS DAYS HOURS MIN. A110 21				Aug. 21, 1	928	28 Maryland				
}	9a. FACILITY NAME (If not institution, give s			ah CITY	TOWN (OR LOCATI				NTY OF OE	-			
œ		DB. CITT												
DIRECTOR	Franklin Squa		R	ossv	<u> </u>	e	Balt	imore	e County					
<u>ပ</u>	10a. STATE 10b. COUNT	10c CI1	Y, TOWN	OR LOCAT	TION					10d. INSIDE CITY				
<u>E</u>	Md. Ba		100.01	1, 101111	on cour		441	e River			LIMITS?			
							e viver			1 TES 2 NO				
₹	10e. STREET AND NUMBER			10	f. ZIP COD			10g. CIT	HAT COUNTRY?					
FUNERAL	1201 Middlew	ay Road						2	1220	220 U				
5	11. MARITAL STATUS	12. WAS OECEDEN									14. RACE	- American Indian, White, etc.		
	1 Never Married 2 Married	IF YES, GIVE Y	YES 2 X	NU			2 NO		n, Puerto Rican, atc.)		Spec/h	y.		
BY	3 Widowed 4 Divorced					White	4							
	15. OECEDENT'S EDU (Specify only highest grade		16a. D	ECEDENT'S	USUAL O	CCUPATI	ON	12	16b. KIND OF BUS	SINESS/IN	DUSTRY			
	Elementary/Secondary (0-12)	College (1-4 or 5	HI HI	Give kind of a. Do NOT u	se retired.)	auring mo	OST OF WORK	ng						
김	6th			Hous	ewi	fo			Own	hon	16			
COMPLETED	17. FATHER'S NAME (First, Middle, Last)			110 (1)	C- 11 T	16	18 MOT	HER'S NA	ME (First, Middle, Maiden		10			
	Wilson J. Bob	litz							ha Jane		rde			
BE	19e. INFORMANT'S NAME (Type/Print)		Ι.			0.40.								
2	- Maria HArman	TARK HARMAN							Route Number, City or Town			1000		
. 1		_	ticoke Court abindon Md.21009											
	20a. METHOD OF DISPOSITION 1													
	4 Donetion 5 Other (Specify)		Holl	y Hi						alti	more	more Md.		
	21. SIGNATURE OF FUNERAL SERVICE LI	CENSEE	1	//			ND ADDRE				. F. D.			
ľ	R. Terry on Connelly Funeral Home of Essex 300 Mace Ave. Baltimore Md. 21221													
		1 on	nece	4										
	23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fellure. Het only one cause on each interval Between												een.	
	IMMEDIATE CAUSE (Final										Onset and De			
	disease or condition resulting in death) e. Pneumonia										48 Hour	S		
	190	DUE TO	(OR AS A CONSI	EOUENCE C	DF):									
z	Respiratory Failure											48 Hour	2	
CERTIFICATION	Sequentielly list conditiona, If any, leading to immediate	DUE TO	(OR AS A CONS	CONSEQUENCE OF):										
8	cause. Enter UNDERLYING	e End Sta	ge Diab	Diabetes									S	
Ē	CAUSE (Disease or Injury that initiated events		(OR AS A CONS		OF):									
	resulting in death) LAST	d												
2														
MEDICAL	PART II. Other aignificent condition	death but not	it not resulting in the underlying ceuse given in					n Part I. 24a. WAS AN AUTOPSY PERFORMED?			WERE AUTOPSY FINDIA	VGS		
8									1 TYES 2 THE			COMPLETION OF CAUS OF DEATH?		
Ψ										- 2				
	DID TOBACCO USE CONT	RIBUTE TO CA	USE OF DE	ATH Y	ES 🗆	NO E	JUNG	CERTAII	v 🗆			1 TYES 2 NO		
A	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one)													
PHYSICIAN:	EXAMINER? 1 YES 2 NO	HOSPITAL:	ED/Outcotters	2 🗆 004	OTHE				• C • C • C • C • C					
₹	27. MANNER OF DEATH	28a. DATE OF		1				lesidenca	6 Other (Specify)	M II III O	NA INCO		_	
	1 Natural 5 Pending	(Month, L	Day, Year)	26b. TH	JURY	W	JURY AT ORK?		26d. DESCRIBE HOW I	NJUHY OC	CURED			
B	2 Accident Investigation						YES 2	_ NO						
-	3 Suicide 6 Could not be	26a. PLACE (building	OF INJURY — At It etc. (Specify)	ome, larm,	street, fed	rtory, offic	CB		26f. LOCATION (Street a City or Town, State)		or Rural R	oute Number,		
E	4 Homicide determined													
COMPLETED	29a. CERTIFIER 1 CERTIFYING PHYS	ICIAN: To the best o	my knowledge, o	death occur	red at the	time, date	and place	e, and due	to the cause(s) and mai	nner aa str	rted.			
Ž	onel											and manner as states	d.	
- 1	2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated.													
BE	296. SIGNATURE AND TITLE OF CERTIFIE	al.	100 -				1	ENSE NUI			TE SIGNEO	(Month, Day, Year)		
2	Carolin No	scrett	M.D				AF.	282	8412-1899		12/1	6/95		
	30. NAME AND AODRESS OF PERSON W													
	Carolyn Garret	t MD. 90	00 Fran	klin	Squa	re I	or.	Balt	o, Md. 212	237				
	DEC 1 91995	3. REGISTA	AR'S SIGNATURE	0 10										
	DEC T 31232	falls all	marker was	ball										

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ed by the		ed at once.
THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FINNERAL DIRECTOR: After this certificate has been stoned by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3	the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	MPDRTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	FOR 1 - STATE REGISTRAR	STATE OF MARYL		RTMENT OF H		MENTAL HYGIEN	E	
,	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH		3. TIME OF DEATH
	Mildred Es	telle 1	Hilliar	ď		December 1	2,1995	12:00AM
	4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE	(In yrs. last birthday)	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)	8, BIR	THPLACE (State or Foreign
ŧ	244 24 2186 so. FACILITY NAME (If not institution, give	1 M 2 XF	82 YRS.		R LOCATION OF DE	May 30,191		rth Carolina
TOR	1305 Old Eastern			Essex			Baltim	
DIRECT	10a. STATE 10b. COUNT	TY	10c. CI	TY, TOWN OR LOCAT	ION			10d. INSIDE CITY
듬	Maryland Balti	more		Essex				LIMITS?
١٢	10e. STREET AND NUMBER				ZIP CODE		10g. CITIZEN OF	WHAT COUNTRY?
FUNERAL	1305 Old Eastern	Avenue			21221		U.S.	.A.
5	11. MARITAL STATUS	12. WAS DECEDENT EVER I				HC ORIGIN? (Specify Years, Puerto Ricen, etc.)	or No- 14. RA	CE - American Indian,
BYF	1 Never Merried 2 Merried 3 Wildowed 4 Divorced	IF YES, GIVE WAR OR D			2 NO Specify		31.14	ecity:
ا ۵	t5, DECEDENT'S EDI	HCATION	AR DECEDENT	LIGHT COORDINA		140 VIND OF BUIL	INESS/INDUSTRY	White
ETE	(Specify only highest grad	le completed)	(Give kind of	Work done during mo	st of working	166. KIND OF BUS	SINESS/INDUSTRY	
	Elementary/Secondary (0-12)	College (1-4 or 5+)		emaker		Own	Home	
COMPL	17. FATHER'S NAME (First, Middle, Last)		IIO	CHEDICE	18, MOTHER'S NA	ME (First, Middle, Maiden		
C	Frank Lewis Car	ter				Bell Smit		
00	19e. INFORMANT'S NAME (Type/Print)		19b, MAILIN	G ADDRESS (Street a	nd Number or Rural I	Route Number, City or Tow	n, State, Zip Code)	-
2	Thomas T. Hillian	rd.	1305	Old East	ern Ave.	Baltimore	, Maryla	and 21221
Ì	20e. METHOD OF DISPOSITION 1 Strive 2 Cremation 3 Ref	20	b. PLACE AND DATE	OF DISPOSITION (Na	me of	DATE 20c. LO	CATION — City or	Town, State
	4 Donation Other (Specify)	HC	olly Hil.	L Mem. Ga	rdens 12	2/15/9 Balt	timore C	b., Md.
	21. SIGNATURE OF FUNERAL SERVICE L	CEMPEE	1.	22. NAME AN	D ADDRESS OF FA	uneral Hom		
- l	Man	elegaçoras	ne					aryland 21221
	23. PART I. Enter the diseases, or	complications that cause	d the deeth. Do					Approximata
	ahock, or heart fellure IMMEDIATE CAUSE (Final	. List only one ceuse on e	each line.	,				Interval Between Onset and Death
	disease or condition	. br	MILL	tui	1101	byin	NIA	
	reaulting in deeth)	DUE TO (OR AS	A CONSEQUENCE	OF):	CON	PVIU	u u u	
z		a Gli	obla	Mota	9			
읟	Sequentially list conditions, if any, leading to immediate	DUE TO (OR AS	A CONSEQUENCE	OF):				
<u>5</u>	cause. Enter UNDERLYING CAUSE (Disease or injury	с.			-			
	that initieted evants resulting in death) LAST	DUE TO (OR AS	A CONSEDUENCE (OF):				
CERTIFICATION	Totaling in dealing exer	d						
AL	PART II. Other significent condition	ons contributing to deeth	but not resulting	in the underlying	cause given in			4b. WERE AUTOPSY FINDINGS
2						PERFOR		AWAILABLE PRIOR TO COMPLETION OF CAUSE
								OF DEATH?
-	DID TOBACCO USE CON	TRIBUTE TO CAUSE (OF DEATH Y	ES NO L	UNCERTAIL	N 🗆		
CIAN: MEDIC	25. WAS CASE REFERRED TO MEDICAL EXAMINER?		28. PLACE OF DE	ATH (Check only one)				
	1 YES 2 DIO	HOSPITAL: 1 Inpatient 2 ER/Out	tpetient 3 DOA	OTHER: 4 - Nursing Horn	5 1 meldence	8 Other (Specify)		
PHYS	27. MANNER OF DEATH	28e. DATE OF INJURY (Month, Day, Year)	28b. TI		URY AT	28d. DESCRIBE HOW I	NJURY OCCURED	
BY	t Natural 5 Pending 2 Accident Investigation			M 1 🗆	rES 2 NO			
ED	3 Suicide 8 Could not be 4 Homicide datermined	28e. PLACE OF INJUR building, etc. (Spe	Y — Al home, ferm, ecify)	atreet, fectory, offic	•	28f. LOCATION (Street City or Town, State)		al Route Number,
4	CONSCR ONLY	SICIAN: To the best of my know						
COMPL	0700) 2 MEDICAL EXAMIN	NER: On the beele of exemination	on end/or investigat	lon, in my opinion, d	eath occured at the	time, date end place, er	nd due to the ceue	e(e) end manner ee stated.
BE C	SHE SHOWETHING AND WILE OF CONCINT	IN AGA.	111		29c. LICENSE NUI	MBER	29d. DATE SIGN	ED (Month, Day, Year)
0	muce	Malle	ms		D330	750	121	12/4(
F	30. NAME AND ADDRESS OF PERSON W	THO COMPLETED CAUSE OF D	EATH (ITEM 27) (Typ	e, Print)	14 1.	1 2 4	11.1	MAZIA
	1703 08	IL X	# 400	100	ulu	Syan	MD	CI COPER
	31. DATE C. Tonti 97995	July 2 DE STANK	A STATE OF THE STA					
		<u></u>						

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TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 5 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely flied in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. DIVISION OF VITAL RECORDS, P.O. BOX 68760

ITEMS:	20b,	20c,	PER	r.H.	FILM	-6-730	12/19/92	L. L				
FOR				STATE	OF M	ARYLAND	/ DEPARTM	ENT OF	HEALTH	AND	MENTAL	HYGIENE

	1 - STATE REGISTRAR	STATE OF N					IEALTH DEAT		MENT	AL HYGIENI REG. NO.	E		
	1. DECEDENT'S NAME (First, Middle, Lest)								2. DAT	E OF DEATH			3. TIME OF DEATH
		James	EDWARD	Н	enso	n			Dec		9. 19	YEAR	6:30 PM
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. les		IF UNDER		IF UNDER	24 HRS.	7. DAT	E OF BIRTH	7, 1	8. BIRTH	IPLACE (State or Foreign
	215-18-6494	1 <u>√</u> M 2 ∏ F	75	YRS.	MONTHS	DAYS	HOURS	MIN.		nth, Day, Year)	1000	Countr	(4)
	9a. FACILITY NAME (If not institution, give s	treet and number)			9b. CITY	r, TOWN (OR LOCATIO	ON OF DE		IL 28.	9c, COUN	TY OF D	YLAND
R	Maryland General	Hospital			Rol-	timo	re C:	i +					
DIRECTOR	RESIDENCE OF DECEDENT	TIOSDICAL			рат	CHIIO	re c.	LLY			Dali	-HIIO	re city
RE	10a. STATE 10b. COUNTY			10c. CITY, TOWN OR LOCATION							10d. INSIDE CITY		
	MARYLAND	N/A		BALTIMORE CITY					1X YES 2 NO				
¥	10e. STREET AND NUMBER					101	. ZIP CODE				10g. CITIZ	ZEN OF Y	WHAT COUNTRY?
FUNERAL	12130 SOUTH LIGH	T STREET					2	1230)		US	SA.	
5	11. MARITAL STATUS	12. WAS DECEOENT	EVER IN U.S. AR		13.	WAS DEC	ENDENT O	F HISPAN	NIC ORIG	IN? (Specify Yea Rican, etc.)	or No-	14. RACE	E — American Indian, k, White, etc.
ВУ	1 Never Married 2 Married 3 Widowed 4 Divorced	IF YES, GIVE W					2 X NO			o recen, etc.)		Speci	
	15. DECEOENT'S EDU	0.000	1										ACK
	(Specify only highest grade	completed)	(G	iive kind of s	CEDENT'S USUAL OCCUPATION The kind of work done during most of working Do NOT use retired.)			10	Sb. KIND OF BUS	INESS/IND	USTRY		
2	Elementary/Secondary (0-12)	College (1-4 or 5+) ""										200
COMPLETED	7th GRADE 17. FATHER'S NAME (First, Middle, Last)			LAB	ORER							AND	RECREATION
									ME (First,	, Middle, Melden S	Surname)		
BE	WALTER HENSON 19a. INFORMANT'S NAME (Type/Print)		100		ADDRES	0.40	EM			mber, City or Town	DAVII		
2		ITE	19										. 21229
	20a. METHOD OF DISPOSITION	III	20h PLACE					SIK	OA				
	1½☐ Buriel 2 ☐ Cremation 3 ☐ Remote 4 ☐ Donation 5 ☐ Other (Specify)	oval from State	MI. ZI	ON CE	METER	YDAD	77	1	15		TINOR		
	21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEE	N. NO				O ADDRES	S OF FAC	CILITY	4-95 WO	0,0,07,1	TIV.	MARYLAND
	b 1/1/5/100	V.ML	1		J	OSEP	н н.	BRO	WN .	JR. FUN	ERAL	HOM	E, P.A.
	and marrie from the state of the	01/0	U		1	913	W. B.	ALTI	MOR	E ST.,	BALTI	LMOR	E, MD.21223
	23 PART I. Enter the diseases, or of shock, or heert failure.	List only one ceur	se on each line	eth. Do r	ot enter	the mo	de of dyi	ng, sucl	h as ca	rdiec or respir	ratory arre	est,	Approximata interval Between
	iMMEDIATE CAUSE (Finel disease or condition	11		~ =									Onset and Death
	resulting in death)	atory F										2 Weeks	
_	DUE TO (OH AS A CONSEQUENCE OF):												
RTIFICATION	Sequentielly list conditions,		OR AS A CONSE			У		-					2 Weeks
¥	if any, leading to immediate cause. Enter UNDERLYING	ic Canc		,.								2 57	
Ĕ	CAUSE (Disease or injury that initiated events	DUE TO (OR AS A CONSEC	QUENCE OF	JENCE OF):						3 Years		
ERT	reauiting in deeth) LAST	d.											
O	PART ii. Other significant condition	s contribution to	death but set s		In Ab					T		_	
SA S	TAIST II. Other aignificant condition	s contributing to	deeth but not r	esuiting	in the ur	nderiying	g ceuse g	Iven in	Part i.	24a. WAS AN A PERFORE		24b.	WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
MED				_						1 - YES 2	NO		OF DEATH?
	DID TODA CCO LICE CONTE	NINI ITE TO CAL	105 05 05 1										1 NES 2 NO
SICIAN:	DID TOBACCO USE CONTI	KIBUIE IO CAL				-	UNC	ERTAIN	<u>и П</u>				
2	EXAMINER?	HOSPITAL:		E OF DEAT	OTHER	P :							
PHYS	1 TYES 2 NO 27. MANNER OF DEATH	1 Cinpatient 2 26a. DATE OF I			-			sidence		er (Specify)			
	1 Netural 5 Pending	(Month, Da		28b. TIM INJ	URY		RK?		28d. OE	ESCRIBE HOW IN	JURY OCC	URED	
B	2 Accident Investigation 3 Suicide & Could not be	28s. PLACE OF	INJURY - At ho	me term r	trant fact	1 📗 Y		NO	201.10	CATION (Course)			San and a san a san a san a san a san a san a san a san a san a san a san a san a san a san a san a san a san
	4 Homicide B Could not be	28a. PLACE OF INJURY — At home, term, street, tectory, office building, stc. (Specify)								CATION (Street ar y or Town, State)	na Number (or Hurai H	loute Number,
29a. CERTIFIER (Check only one) 2 Image: MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and manner as stated.													
	The control of the cause and place, and due to the cause and place, and due to the cause and men) and menner as stated.				
씱	29b. SIGNATURE AND TITLE OF CERTIFIER		m~				950 LICE	NSE NUM	MBER		29d. DATE	SIGNEO	(Month, Day, Year)
2	30. NAME AND ADDRESS OF PERSON WHO		F OF DEATH ATE	M 27) /=-	Deleve)		150	7/1			10	4/	7/45
}						7	т:		1				
	Dr. Pornchai Jong] 31. DATE FILED (Month, Day, Year)	PS2. REGISTRAS		TANG	Gene	eral	HOS	ita.	1				
	DEC 1 91995	Julia dhuo	40x-Randa	Ц									

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funeral director, page 5 should be detached for use as the burial-transit

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other traumatic event.

PHYSICIAN:

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cremation, the

Pages 1, 2, 3 should

permit.

filled in by the fillion, or removal. and completely fi to burfal, cremation anding physician an Hygiene prior to b OR ATTENDING PHYSICIAN: The law requires that the death certificate be TO THE FUNERAL DIRECTOR: After to the filed within 72 hours after death IMPORTANT: It item 28 is man

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR CERTIFICATE OF DEATH REG. NO. t. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH December 10 1995 Hawkins 12:05 Olivia A 4. SOCIAL SECURITY NUMBER IF UNDER 1 YEAR IF UNDER 24 HRS. 8. AGE (In yrs. last birthday) 7. DATE OF BIRTH s. BIRTHPLACE (State or Foreign AUG. 26, 1 M 2 F 1949 46 220-64-7558 MARYLAND 9e. FACILITY NAME (If not inetitution, give street end number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Maryland general Hospital Baltimore City Baltimore City RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY BALTIMORE CITY N/A MARYLAND X YES 2 NO FUNERAL 10e. STREET AND NUMBER IN ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 21216 1127 ASHBURTON STREET USA. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or Noif yes, specify Cuban, Mexicen, Puerto Rican, etc.)
t YES 2 NO Specify: t4. RACE — American Indian, Black, White, etc. t 🗌 Never Merried 2 📉 Merried Specify: BY 3 Widowed 4 Divorced BLACK 16a. DECEDENT'S USUAL OCCUPATION 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only high (Give kind of work done life. Do NOT use retired.) ET Elementery/Secondery (0-12) College (1-4 or 5+) COMPL NURSING HOME NURSING 12th GRADE 2yrs. 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Surneme) RICHARDSON WHITTINGTON JOSEPH OLIVIA t9e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 2410 WINCHESTER STREET, BALTIMORE, MD. 21216 LATRONDA HAWKINS 20a METHOD OF DISPOSITION
1 XBurlet 2 Cremation 3 Ram 20b. PLACE AND DATE OF DISPOSITION (Name of 29c. LOCATION - City or Town, Stata DATE ARBUTUS CEMETERY 4 Donation 5 Other (Specify) 12-15-9\$ ARBUTUS, MARYLAND 21. SIGNATURE OF FUNERAL SERVICE LICENSEE JOSEPH H. BROWN JR. FUNERAL HOME, P.A. 1913 W. BALTIMORE ST., BALTIMORE, MD.21223 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. interval Between Onset and Death IMMEDIATE CAUSE (Final disease or condition Squamous Cell Cancer Of Cervix Stage Three B recuiting in death) DUE TO (OR AS A CONSEQUENCE OF) CERTIFICATION Sequentially ilst conditione, DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initieted events resulting in death) LAST PART II. Other aignificent conditions contributing to deeth but not resulting in the underlying ceuse given in Part I. 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS MEDICAL

PERFORMED? 1 TES 25 NO

AWAII ARLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO X UNCERTAIN 26. PLACE OF DEATH (Check only one 25. WAS CASE REFERRED TO MEDICAL HOSPITAL: OTHER:
4 | Nursing Home 5 | Residence 8 | Other (Specify) 1 Sympatient 2 ER/Outpetient 3 DOA

1 TES 2 NO 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 1 Netural
2 Accident 5 Pending Investigation

6 Could not be

28d. DESCRIBE HOW INJURY OCCURED 28b. TIME OF 28c. INJURY AT WORK? 1 YES 2 NO

89233

281. LOCATION (Street and Number or Rural Route Number City or Town State)

12/10/95

29e. CERTIFIER
(Check only one)

CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end piece, end due to the cause(s) and manner ee stated. 2 MEDICAL EXAMINER: On the beele of exemination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(e) and menner se stated.

26e. PLACE OF INJURY — At home, term, street, fectory, office building, etc. (Specify)

29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year)

Sall BACUTS TOA A. 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

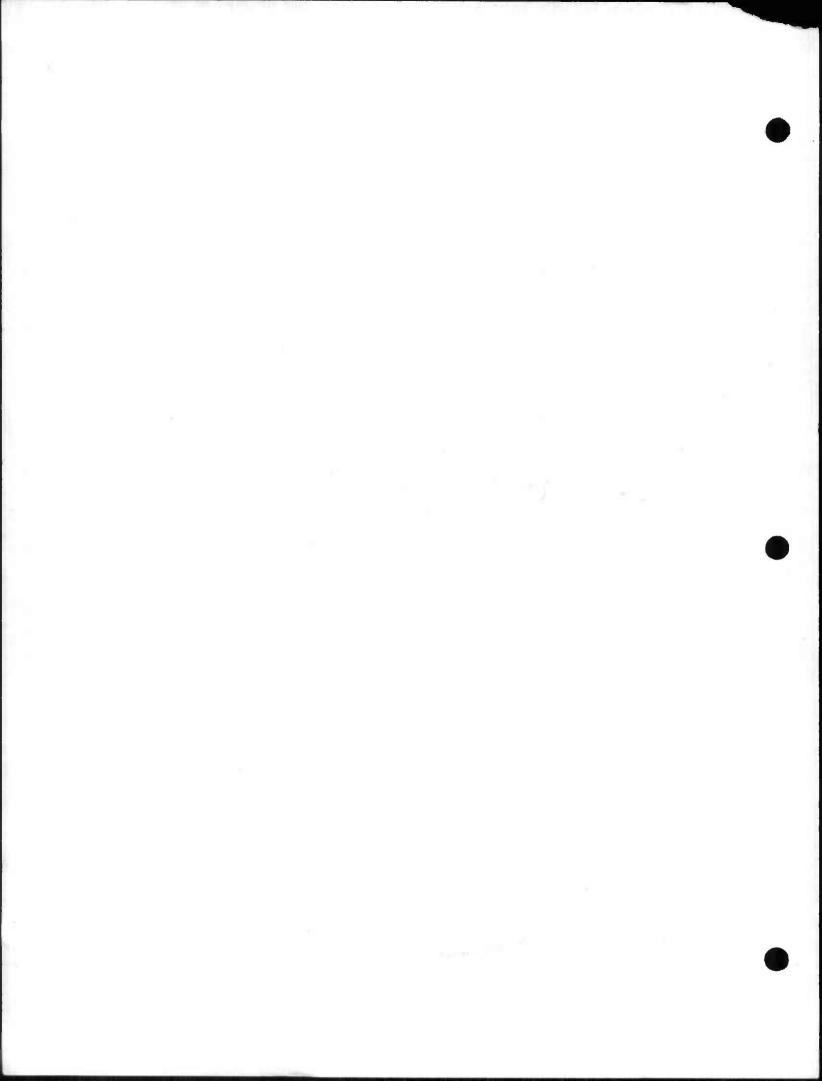
Dr. Arisimah Bautista C/O Maryland General Hospital

31. DELL 9 1995

3 Suicide

4 Homicide

32. REGISTRAR'S SIGNATURE



95-7463-510

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

ITEMS: 23 PART I, 27, 28a-f, PER, State of Maryland / Department of Health and Mental Hygiene 9 5 MEN ETIM 6-731 1/11/96 t.t

MICHAEL

MED FILM U-7	31 1/11/30	
	1. Decedent's Nama	(First, Middle, Last)
Physician	CRAIG	KEEFE

Certificate of Death 2. Date of Death 3. Time of Death

Physician	
/Medical	1
Examiner	

with the Meryland

death

permit. Peges 1 and 2 should be flied within 72 hours efter. Department of Health and Mental Hygiena. Introchant: If flem 21 is marked other than "natural", or free any Injury or other traumatic event.

Physician

/Medical

Examiner

use es the burial-transit

nding physician

ed by the e

signed by t

ate has been signated page 2 should b

cartificate

After this

Maryland 21215-0020

Baltimore,

Box 68760,

P.O.

Division of Vital Records,

or Attending Physician:

death.

after death

To the Hospital of within 24 hours at To the Funeral C completely filled

in by t

The law requires thet the death certificate be-

4e. Fecility Nema (If not institution, giva street end number) JOHNS HOPKINS HOSPITAL

HOWARD

Month Year 95 5:15 4b. City, Town, or Location of Death 4c. County of Deeth

5. Social Security Number **Funeral** Director 214-43-0588

7. Age (In yrs. last birthday) 11 M 2□ F

BALTIMORE If Undar 24 Hrs. 8. Data of Birth (Month, Day, Year) If Under 1 Yeer Days Months

N/A Birthplace (Steta or Foreign Country)

P.M

N☐ Yes 2☐ No

Usual Rasidance of Decedant r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

Director

9

Completed

Be

2

Examiner

Physician/Medicai

by

Completed

Be

2

Certification:

edicai

10a, Stata 10b. Count N/A

10c. City. Town or Location

OCT. 23, 1994 MARYLAND 10d. Inside City Limits

MARYLAND 10e. Street end Number BALTIMORE 10f. Zip Code

10g. Citizen of What Country?

USA.

3718 FAIRHAVEN AVENUE

0

1 Navar Married 2 Married 3 Widowed 4 Divorced

12. Wes Dacedent Ever In U.S. Armed Forcas?

1 Yas 2 No
If Yes, Giva Year or Dates:

13. Wes Decedant of Hispenic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 1 ☐ Yas 2 XNo Specify:

14. Rece - American Indian Black, White, etc. Specify: BLACK

15. Decadent's Education (Specify only highest grade completed) Elamantary/Secondery (0-12)

College (1-4or 5+)

16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa retired)

21226

16b. Kind of Business/Industry NONE

17. Fathar's Nama (First, Middla, Last)

BRIAN K. ANDERSON 18. Mothar's Nama (First, Middle, Maidan Sumama)

SHERRI

HOWARD

19a. Informent's Name/Ralationship (Type, Print)

19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Code)

SHERRI 20a. Mathod of Disposition

HOWARD 1 🛣 Buriai 2 ☐ Cremetlon 3 ☐ Ramovel from Stata 4 ☐ Donation 5 ☐ Other (Specify)

20b. Placa of Disposition (Nama of camatary, crematory or other placa) CROWNSVILLE CEMETERY

NONE

3718 FAIRHAVEN AVENUE, BALTIMORE, MD. 21226 Data 20c. Location - City or Town, Stata

12-14-95 CROWNSVILLE, MARYLAND

21. Signature of Funerel Saprice Licensea

22. Name end Addrass of Facility
JOSEPH H. BROWN JR. FUNERAL HOME, P.A. 1913 W. BALTIMORE ST., BALTIMORE, MD.

234 Part1. Ente the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiretory errest, and failure. List only one cause on each line. 21223 Approximeta Intervel Batween Onset and Death

Immedieta Causa (Final disaasa or condition resulting in deeth)

INTRACRANIAL HEMORRHAGE

Due to (or as a consequence of)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury thet initiated events resulting in deeth) Last

Dua to (or as a consequence of):

Due to (or as a consequence of)

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown

24a. Wes en autopsy performed?

24b. Ware autopsy findings evallable prior to completion of cause of deeth?

Yas 2□ No

1 Yas 2 No

25. Was case refarred to medical 1X Yes 2 No

27. Mannar of Death 1 Naturel 5 Pending Investigation 2 Accident

28a. Deta of Injury (Month, Day Year) 28b. Time FOUNDury 28b. Time of OUND: 12/7/95 5:15

Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at Work? 1 ☐ Yas XX No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Dascribe how injury occurred

6(X) XXXd not be datarmined 28a. Place of Injury - At homa, farm, streat, factory, offica building, atc. (Specify) 4 Homleida FOUND AT HOME

28f. Location (Street and Number or Rural Route Number OF City or Town, Stata) 3/18 FAIRHAVEN AVENUE BALTIMORE, MARYLAND

29a. Cartifian (Check only one)

3 ☐ Sulcide

1 Cartifying Physician: To the best of my knowledge, daath occurred at the time, deta and place, and due to the cause(s) and manner as stated.

2 Madical Examiner: On the basis of axamination and/or invastigation, in my opinion, deeth occurred at the time, data and piece, and due to the cause(s) and manner stated. 29c. Licansa number 29d. Data signed (Month, Day, Year)

HINK NOWN

26. Place of Death (Check only ona)

29b. Signatura and title of cortifier

O.C.M.E.

DECEMBER 9,1995

30. Name and address of person who completed cause of death (Itam 23a) (Type, Print)

rowler

111 Penn Street, Baltimore, Maryland 21201

State Registrar



E STATE OF S Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

9	0	_	/	О	О	O	_	S	Τ	١
Λ	M									

State of Maryland / Department of Health and Mental Hygiene 5 AMCertificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Time of Courth Month Day DEC.16,1995 **Physician JEFFERSON** 00:42 A ERICA RENEE /Medical 4a. Facility Nama (If not Institution, giva streat and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 300 BLK. EDSDALE RD. BALTIMORE 8. Data of Birth (Month, Day, Year) 9. Birthpiaca (Stata or Country) Apr. 23,1979 Maryland 5. Social Security Number If Undar 1 Yaar If Undar 24 Hrs. 7. Aga (In yrs. last birthday) Birthpiaca (Stata or Foreign Country) **Funeral** Months Days 1 M 2 S F Hours Yrs. Director 217-92-9119 16 Usual Rasidence of Decedant the Maryland 10a Stata 10c. City, Town or Location 10b. County 10d. Insida City Limits 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at Maryland 1 Yas 2 □ No N/A Director **Baltimore** 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? with 403 Edsdale Road 21229 USA 2 should be filed within 72 hours after death von and Mental Hygiana.
Is marked other than *natural; or items 23 Funeral 12. Was Decedant Evar in U,S. Armed Forcas? Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - American Indian, Black, Whita, atc. 11. Marital Status 1 Navar Married 2 Married 1 ☐ Yas 2X No If Yas, Giva Baltimore, Maryland 21215-0020 1 Yas 2 No Specify. Specify: þ f Yas, Giva Yaar or Datas: Black 3 Widowed 4 Divorced Completed 18a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Businass/Industry Elamantary/Secondary (0-12) Collaga (1-4or 5+) 11th N/A N/A 17. Fathar's Nema (First, Middla, Last) 18. Mothar's Nama (First, Middla, Malden Sumama) Be Kenneth Jefferson Bernice Hicks 2 19e. Informent's Name/Ralationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) permit. Pagas 1 and 2 st Department of Haaith and Important: If Item 27 is n any Injury or other traun Mable Hicks, grandmother 4542 Mountview Road, Baltimore, MD. 21229 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20c. Location - City or Town, Stata 20a. Mathod of Disposition Data 1 Burial 2 Cremation 3 Ramoval from State 12/21 Randallstown, MD 4 ☐ Donation 5 ☐ Othar (Specify) King Memorial Park AFunaral Sarvica Licansaa 22. Nama and Addrass of Facility Leroy O. Dyett & Son Funeral Home, 4600 Liberty Heights Avenue tree the disease or complications the causad the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, or heart failure. Ust only one causa or each line. Approximata Intarval Between Onset and Death **Physician** /Medical Immediata Cause (Final disaasa or condition rasulting in daath) Gunshet wound to head Examiner Dua to (or as a consequence of) Examiner the burial-transit Sequantially list conditions, if any, laading to immadiate causa. Entar Undarlying Causa (Disaasa or injury that initiated avants rasulting in daath) Last and Due to (or as a consequence of): Box 68760. physician certificata be Physician/Medicai Dua to (or as a consequence of): as. attending usa Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. 23b. Did tobacco use contribute to the cause of death? tha signed by t 1 TYee 2 No 3 Probably 4 2 Unknown 10cm by 24b. Wara autopsy findings available prior to completion of cause of daath? 24a. Was an autopsy performad? Completed peen page 2 s has 1 X Yas 2 □ No 1 2 Yas 2 □ No cartificata 25. Was casa raferred to madical axaminar? Be 26. Pleca of Daath (Check only ona) Other: 4 Nursing Home 5 Residence 8 Nother (Specify) STREET Hospital: 1 ☐ Inpailant 2 ☐ ER/Outpatient 3 ☐ DOA 2 1 X Yas 2 □ No 27. Mannar of Daath 28b. Tima of injury 28c. Injury et Work? 28d. Dascribe how injury occurred 28a. Data of Injury (Month, Day Year) Certification: Director: Aftar 5 Panding invastigation or Attending 1 Natural Sulgest Shot

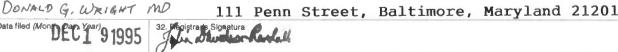
281. Location (Street and Number or Rural Routa Number,
City or Town, Steta) 300 Block daath. 0019 1 Yas 2 No 2 Accident 12/16/95 6 Could not ba datarmined 3 Suicida 28e. Placa of Injury - At homa, farm, street, factory, office building, etc. (Specify) hours after 4 X Homicide STREGT Edsdale Road, Baltimore MO 24 hours a Hospital 29a. Cartifier 1 Certifying Physician: To the best of my knowladge, death occurred et the time, dete and piace, and dua to the ceuse(s) and mannar as stated. Medical 2 Medical Examiner: On the basis of axaminetion end/or investigetion, in my opinion, deeth occurred at the time, deta and place, end due to the cause(s) and manner stated. plataly To the I within 2 To the P

State Registrar

29b. Signatura and titla of cartifiar

Donald & Whight MD

30. Nama and addrass of person who complated causa of deeth (Item 23a) (Type, Print)

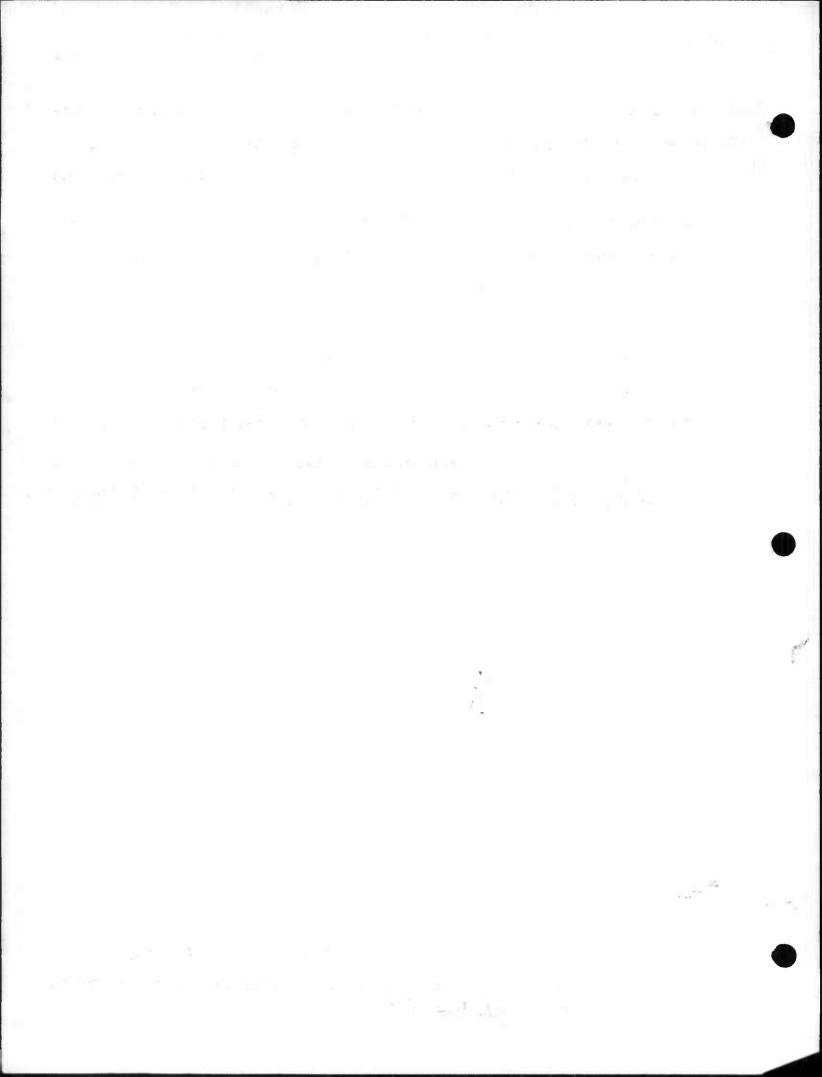


29c. Licansa number

OCME

29d. Data signed (Month, Day, Year)

DEC. 16, 1995



BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

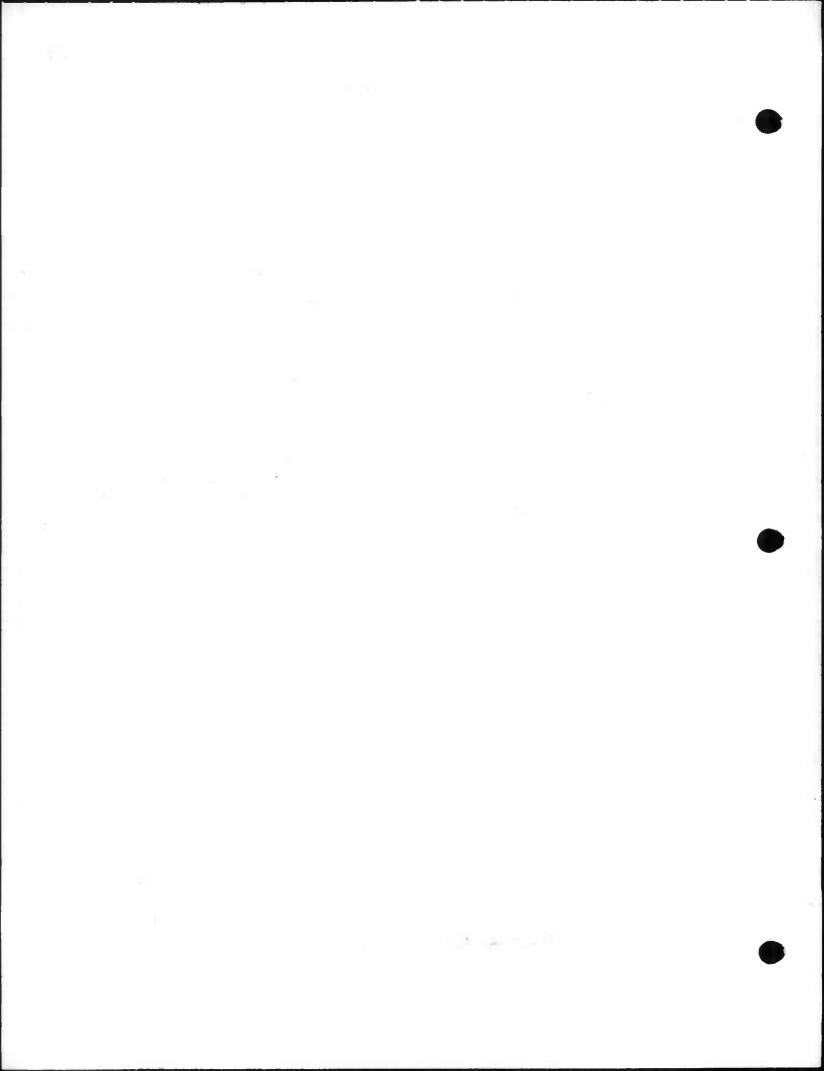
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death cartificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAR	CERTIF	CATE OF	DEATH	REG. NO	_					
	1. DECEDENT'S NAME (First, Middle, Last)				2. DATE OF DEATH		3, TIME OF DEATH				
	KEINER JENWINGS					YEAR	- 1				
		yrs. lest birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	1 17	7.3	-7:00 M. W				
			MONTHS DAYS	HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year)		RTHPLACE (State or Foreign untry)				
	221 10 0012	3 ms.			Dec 16,19	119 工	LINOIS				
	9a. FACILITY NAME (If not institution, give street and number)		9b. CITY, TOWN	OR LOCATION OF DE	EATH	9c. COUNTY O	F DEATH				
9	2103 FOLKSTONE Rd.		Timo	nium		RALT	imores				
5	RESIDENCE OF DECEDENT					1 21/2/	11.01/				
DIRECTOR	10a. STATE 10b. COUNTY	10c. CIT	, TOWN OR LOCA	TION			10d. INSIDE CITY LIMITS?				
	MARY AND BALLIMORS	1	inoni	mu			1 TES 2 NO				
A A	10s. STREET AND NUMBER		10	. ZIP CODE		10g. CITIZEN O	F WHAT COUNTRY?				
E .	2103 FOLKSTONE Rd.			2100	2	10.	Ω 7				
FUNERAL	11. MARITAL STATUS 12. WAS DECEDENT EVER IN	U.S. ARMED	13. WAS DEC	ENDENT OF HISPAN	IIC ORIGIN? (Specify Yes	or No. 1 st. Pr	ACE — American Indian,				
	1 Never Married 2 Married FORCES? 1 YES	2 NO	If yes, sp	ecify Cuban, Mexica	n, Puerto Rican, atc.)	BI	ack, White, atc.				
BY	3 Wildowed 4 Divorced	E3	1 U YES	2 NO Specify	ŗ:	Sp	Hecity:				
ETED.	15. DECEDENT'S EDUCATION	16a DECEDENT'S	USUAL OCCUPATION	OM.	16b. KIND OF BUS	This control to the	003(1)2				
	(Specify only highest grade completed)	(Give kind of v	rork done during mo	ast of working	100. KIND OF BUS	SINE 35/INDUSTRY	1				
12	Elementary/Secondary (0-12) College (1-4 or 5+)	-	,	-0	118	Sauce	Large				
S OTTLE ENGINEER OF GOVERNMENT											
18. MOTHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Melden Surname)											
<u>w Samuel Newton Jennings</u> Dora Ann Allaid											
2	19a. INFORMANT'S NAME (Type/Print)	19b. MAILING	ADDRESS (Street a	and Number or Rural I	Route Number, City or Town	n, State, Zip Code)					
-	CATHERINE Jennings	1210	3 FOLKS	TONE Rd	, Timoniur	n.Md.	21093				
			F DISPOSITION (Na			CATION — City or					
	4 Donation 5 Other (Specify)	tery, cremetory or of	her plage)	VASSY	13278 B	D. Q (PARYLAGO				
	21. BIGRATURE OF FUNERAL SERVICE LICENSEE										
EVAN CHAPET OF CHILDES											
	Lines & Course - 2325 YORK 120 AD - Timorium										
	23. PART I. Enter the diseases, or complications that caused shock, or heart feliure. List only one cause on as	the death. Do n	ot enter the mo	de of dylng, suci	h as cardiec or reapi	ratory arrest,	Approximata				
1 1	IMMEDIATE CAUSE (Finel	on line.					interval Between Onset and Death				
		10.1					Onset and Death				
	resulting in death) a. OUE TO (OR AS A (disease or condition resulting in death) a. ASPIR ATION OUE TO (OR AS A CONSCOUENCE OF):									
_	Sequentially list conditions a CEREBROYASCULAR ACCIDENT 14ear										
CERTIFICATION	DIJE TO (OR AC A COMPENSATION OF										
M	if any, leading to immediate cause. Enter UNDERLYING										
[윤]	CAUSE (Disease or injury that initiated events DUE TO (OR AS A C	ONSFOLIENCE OF									
Ē	resulting in death) LAST	JOHOL GOLHOL OF	J .								
原	d										
1 _1	PART II. Other significent conditions contributing to deeth but	not resulting in	n the underiving	ceuse given in	Part I. 24a. WAS AN	ALITOPSV 2	4b. WERE AUTOPSY FINDINGS				
S	mitral valve disease		,		PERFOR	MED?	AMAILABLE PRIOR TO COMPLETION OF CAUSE				
	The proof of the payer				1 YES 2	DE NO	OF DEATH?				
₹						.	1 YES 2 NO				
z	DID TOBACCO USE CONTRIBUTE TO CAUSE OF	DEATH YE	S 🗆 NO 🗷	UNCERTAIN	1 🗆						
SICIAN:		S. PLACE OF OEAT									
Si	1 YES 2 NO HOSPITAL: 1 Inpatient 2 ER/Outpat	lent 3 DOA	OTHER: 4 Nursing Hom	5 XBasidence	6 Other (Specify)						
T 27. MANNER OF DEATH 288. DATE OF INJURY 286. TIME OF 28c. INJURY AT 28d. DESCRIBE HOW INJURY OCCUREO											
	1 Netural 5 Pending (Month, Day, Year)	INJ	M 1 1	RIC? /ES 2 NO							
BY	200 PLACE OF IN HIEV	- At home, farm, si	reet, factory, office		281. LOCATION (Street a	nd Number or Run	I Bouts Number				
	4 Homicide determined building, atc. (Specify)	, , , , , , , , , , , , , , , , , , , ,	·	City or Town, State)	na reaniber or none	r noote number,				
i i	29a. CERTIFIER										
<u>a</u>	(Check only 1 CERTIFYING PHYSICIAN: To the best of my knowled										
COMPL	one) 2 MEDICAL EXAMINER: On the basis of examination	end/or Investigation	ı, in my opinion, d	eath occured at the	lime, data and place, and	due to the ceus	e(a) and manner as stated.				
U C	296. SIGNATURE AND TITLE OF CERTIFIER 294. DATE SIGNED (Month), Day, Year)										
8	James 14 Ridding And			117	7	M /4	(Morte, Dely, Year)				
임	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEAT	WATER OF CT.	Delet	1177	10	- 14	14/17				
				D 1.1	/ 15	17 11/					
	JAMES DIDDROW 74		er In	12 or 46	s, and V	Loga					
1	31. ONTE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNAT	URE					7				
	The sound of the s	4									



		EMS	05 : 23 PART I, 27, f, PER MEO FILM G-731	Type or Print State of Man				-			3241
			96 t.t			Certificate o	of Death	Re	eg. No.		
ı	Physic	an	1. Decedant's Nama (First, Middla, Last, L. EON			JAMERSON		2. Date of Deat Month DEC 1		95	3. Tima of Deeth
	/Medi Exami		4a. Facility Nama (If not institution, giva. 3648 WASHINGTON	street and number)		34	4b. City, Town, or		4c. County		12:51
t	Funeral Director		Social Security Number 6. Sax	7. Aga (//	n yrs. last birth	nday) If Undar 1 Ya Months Da		8. Data of Birth (Month, Day, 03/31		9. Birthpla Countr	aca (Stata or Foraign
	_		Usual Rasidance of Decedant	`	30			03/31	/95	MARY	LAND
	death with the Meryland rms 23e or 28e-f ehow	tor	10a. Stata 10b. County MD • N/A		oc. City, Town					10	d. Insida City Limits 1 Yas 2 No
	or 28	Director	10e. Street and Number	,		10f. Zlp Cod	a	1	0g. Citizan of 1	What Countr	ry?
	23a	rai	701 N. LONGWOO	D STREET		212	16		USA	ł.	
		Funeral		12. Was Decedant Eva Armed Forcas?	r In U,S.	13. Was Decedant of If Yas, specify C	of Hispanic Origin? (S Juban, Maxican, Puar	ipecify Yas or No- to Rican, atc.)		e - Amarica ck, Whita, at	
0020	72 hours efter natural, or ite	þ	1 X Navar Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yas 2 XNo If Yas, Giva Yaar or Datas:		1 □ Yas 2 🔯 I	No Specify:		Specify	y:	ACK
Maryland 21215-0020	thin e.	Completed	15. Decedant's Edu (Specify only highast grade Elamantary/Secondary (0-12)	cation a com <i>platad)</i> Collega (1-4or 5+)		life. DO NOT usa re	na during most of wo	rking	16b. Kind of B	usinass/Indu	istry
d 2	be filed wintel Hygien of other the		12th 17. Fathar's Nama (First, Middla, Last)		L.A	BORER	18 Mother's Na	ma (First, Middla, M	STEEL	201	
rylan	75 5 0	To Be	MELVIN WILLIAM				WILEA	N POLL	ARD		
Ma	70 50 50		19a. Informant's Name/Relationship (Ty				eet end Number or Ri				
Baltimore,	Heel Heel Item 2		BERKLEY POLLA 20a. Mathod of Disposition 17 Buriai 2 □ Cramation 3 □ R	amoval from Stata	20b. Placa of I camatary	Disposition (Nama of , crematory or other	place)	Data	20c. Location -	City or Tow	vn, Stata
tim	permit. Pege Department of Important: If any Injury or page.		4 Donation 5 Othar (Spacify)		CING M		PARK 12	-19-95	RANDAI	LSTO	WN, MD.
Ba	permit. Pe Departmer Important any Injury once.		21. Signature of Funeral Service License			ALBERT	P. WYLI GILMOR	E F/H I	PA 21217	7	
	L II		23a. Part1. Entar tha disaasa, or compli shock, or haart failure. List only or	cations in a lised tha	daath. Do no	ot anter tha moda of	dying, such as cardia	c or raspiratory arra			Approximata Intarval Between
	Physician /Medical Examiner		Immediata Causa (Final disease or condition rasulting in death)			IC INTOXICA					Onsat and Death
	THE R.	Jer		Due	to (or es a co	onsequence of):					
ó	be executed ician and buriel-transit	Examiner	causa. Entar Undarlying								
x 68760,	phys the	Physician/Medical	Cause (Diseesa or Injury that initiated avents rasulting in death) Last	Dua to (or as a consequence of):							
Box	etter for u	sian									
0	thet the de ad by the deteched	ysi	Part II. Other algnificant conditions con	tributing to death but no	ot rasulting in	tha undariying causa	givan In Part I.				the cause of death?
σ,	es thet igned b	by PI						1 🗆 Ye	s 2 No	3 Probe	ably 4 Unknown
Records,	been s	Completed b						24e. Was ar	n autopsy ned?	avai	re autopsy findings llabla prior to apletton of cause aath?
Re	The lew ate hes t page 2 s	dmo						1 KYa	s 2 No	L	Yas 2 No
Vital	delan: The	BeC	25. Was casa raferred to medical				26. Place of Da	ath (Chack only on			L 20 110
of V	5 00	ToE	exeminar? 1X Yas 2 □ No	ospitai:	2 ER/Out	patient 3 DOA	Other	loma 5□ Reside		ar (Specify)	SCENE
iono	After fune		27. Mennar of Deeth 1 Natural 5 Pending 2 Accident investigation	28e. Deta of Injury (Month, Dey Ya FOUND: 12-14		1.2	njuryat Work? I∐ Yas 2XXX No	28d. Describe ho	w Injury occur	red	
Division	를 걸음 호	Certification:	3 Sulcida 6 XX Sould not be detarmined	28a. Place of Injury - building, atc. (S FOUND: MOT	ipecify)	n, street, fectory, offi	се	28f. Location .SI 3648 WASH			
	To the Hospital or within 24 hours efter To the Funeral Dir completely filled in	edical (29e. Cartifiar (Check only one)	ician: To the best of more: On the basis of axa	y knowledge,	deeth occurred at the or invastigation, in m	a tima, date and place by opinion, daath occu	, and due to the ca pred at the tima, de	use(s) end me	enner as sta	ited. tha cause(s)
	within 2 To the comple	Me	29b. Signature and title certifiar		1		ansa number	25	od. Data signe DEC	d (Month, D	lay, Year)
	1		1 Theodore	M. Kmg	2 mg	>	C.M.E		DEC	14,19	195
	5		30. Nama and addrass of person who co	mpleted cause of dash	(Item 23a) (T	Penn Str	eet, Bal	timore,	Mary	land	21201
ľ	Sta	te	31. Day filed (Month, Day, Year)	32. Registrar's	Signature						.7

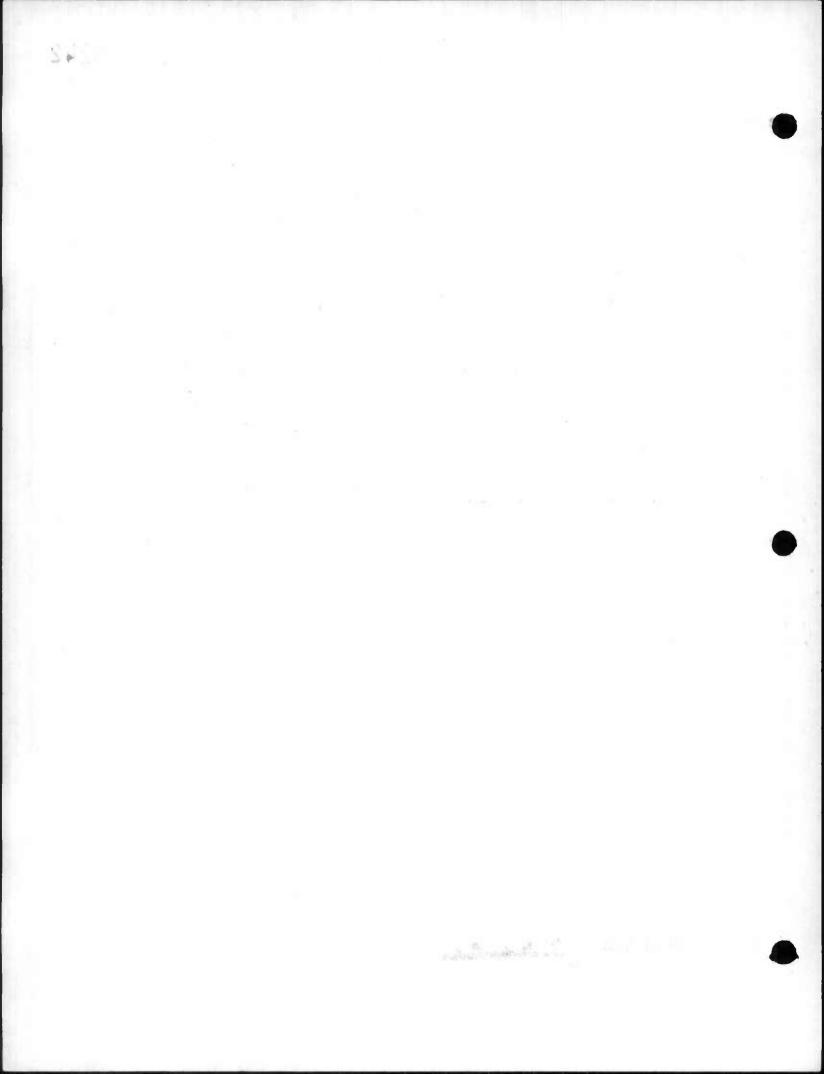
DHMH 16 Rev 6/95

DHMH-16 Rev 1/89

THE HOSPITAL OR A fled within 72 hours	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 27 mours after death. Page 6 may be retained by the hospital properties of the second of the properties of	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached a within 70 hours after death with the State Deat of Health and Mental Hodger onto the build cremation, or removal.	IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.
THE HOSPITAL OF THE FUNERAL DISTRICT WITHIN 72 how IPPORTANT: If 116	R ATTENDING	RECTOR: After	m 28 ls m
	THE HOSPITAL OF	THE FUNERAL DI	PORTANT: If Ite

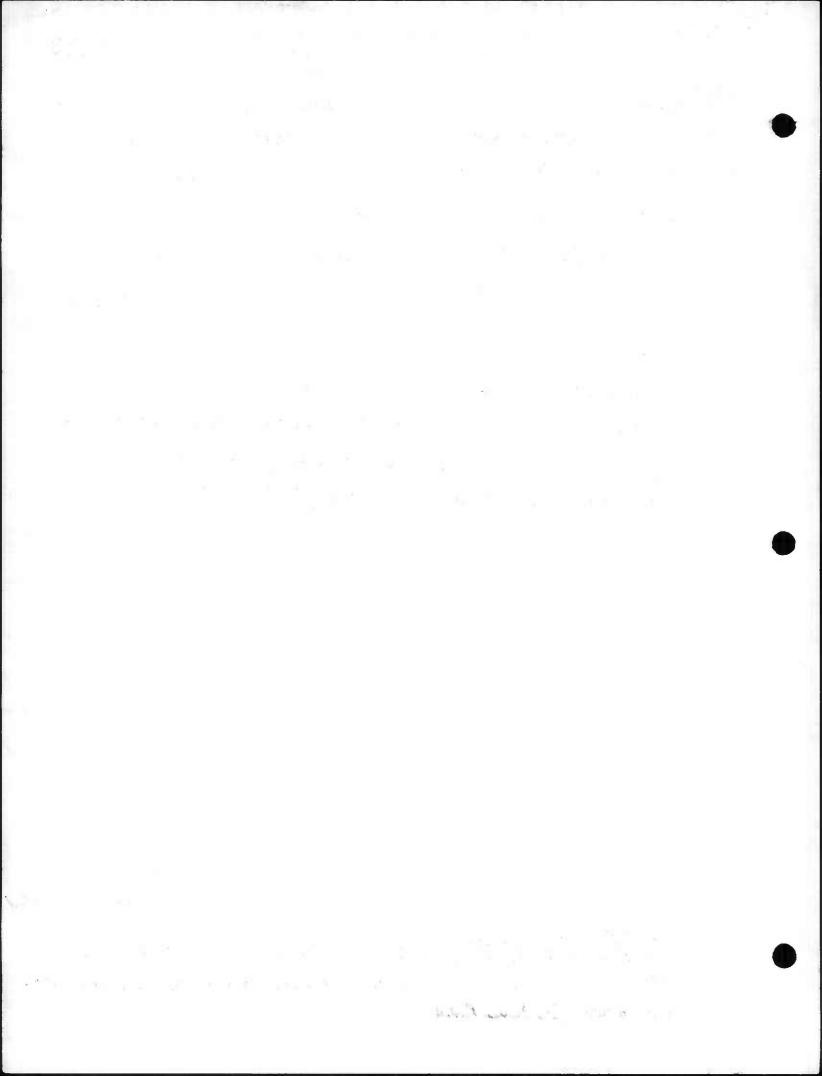
	STATE OF MARYLAND / DEPARTMENT OF HEALTH AND I CERTIFICATE OF DEATH	MENTAL HYGIENE REG. NO.	
Aiddle, Last)		2. DATE OF OEATH MONTH DAY	

FOR 1 - STATE REGISTRAR	STATE OF MARYL		MENT OF H			IYGIENE NEG. NO.				
1. DECEDENT'S NAME (First, Middle Eric Jaco	e, Lest) bsen				2. DATE OF MONTH 12		YEAR 95	3. TIME OF DEATH		
4. SOCIAL SECURITY NUMBER 213 05 8898			IF UNDER 1 YEAR NONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF 1 (Month, De 7-4-0	BIRTH ay, Year)	Count	HPLACE (State or Foreign		
Broadmead, 13	801 York Road		ob. CITY, TOWN C Cockeys	r location of de	EATH		UNTY OF E			
10e. STATE 10b.	RESIDENCE OF DECEDENT 100. STATE 100. CITY, TOWN OR LOCATION MARYLAND BALTIMORE COCKEYSVILLE							10d. IHSIDE CITY LIMITS? 1 YES 2 NO		
	STREET AND NUMBER 101. ZIP CODE 10g. CITIZE							ZEN OF WHAT COUNTRY?		
100. STREET AND NUMBER 13801 YORK 11. MARITAL STATUS 1 Hever Married 2 Marrie 3 Widowed 4 Divorced	ARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECEMENT OF HISPANIC ORIGIN? (Specific FORCES? 1 YES 2 HO If yes, specify Cuban, Maxican, Puarto Rican, etc. 1 YES, GIVE WAR OR DATES									
	r's EDUCATIOH st grade completed) College (1-4 or 5+) 5 +		rk done during mo retired.)	GILLETT		HD OF BUSINESS/II				
	Last)	CEO. M.	ARTIN-		ME (First, Midd	A COMPA No. Meiden Surname; FITHS				
19a. IHFORMANT'S NAME (Type/Pri				nd Number or Rural	Route Number,	City or Town, State, 2		32738.		
20e. METHOD OF DISPOSITIOH 1 Burlal 2 Cremation 3 4 Donation 6 Other (Spec	□ Removel from State	REEN MO		netery, cremetory or EMATORY	12/9	20c. LOCATION -				
21. SIGNATURE OF FUHERAL SER	L. Luis III	•	HENR	D ADORESS OF FA Y W. JE YORK R	NKINS					
shock, or heart is shock, or heart is shock, or heart is shock, or heart is shock, or heart is shock, or heart is shock, or heart is shock, or heart is shock, or heart in the shock, o	DUE TO (OR AS		:	MOIOUM	SCUL	AR DIS	EKE	Interval Between Onset and Death		
25. WAS CASE REFERRED TO MEI EXAMINER? 1 VES 2 100 27. MAHNER OF DEATH	enditions contributing to deeth	but not resulting in	the underlyin	g cause given in		A. WAS AN AUTOPS PERFORMED?	Y 24	b. WERE AUTOPSY FINDINGS MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO		
25. WAS CASE REFERRED TO MEI	HOSPITAL:	T.	26. P	ACE OF DEATH (C)	neck only one)					
1 VES 2 NO	1 Inpetient 2 ER/Ou	tpatient 3 DOA 28b. TIME	4 Nursing Hon	e 5 Residence		pecify)	OCCURED			
2 Accident Invest	igation 28e. PLACE OF INJUR	IY — At home, ferm, at	M 1 🗆	PRK? YES 2 HO	28f. LOCATIO	ON (Street and Numi	ber or Rural	Floute Number,		
4 Homicide detan	mined					lown, State)				
(Check only 2 MEDICAL	G PHYSICIAN: To the best of my kno EXAMINER: On the basis of examinat							(a) and menner as stated.		
296. SIGHATURE AND TITLE OF	entifier the			29c. LICEHSE NU	MBER 450	29d. D	ATE SIGHE	(Month Day, Year)		
30. NAME AND ADDRESS OF PER	SOH WHO COMPLETED CAUSE OF D	3746		LMILL	Ro	PATONENI	×u	W 21121		
31. DATE FILED (Month, Day, Year) DEC1 9 1995	32. REGISTRAR'S SIG	NATURE						.,,		



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 5 38243

			C	ertificate of De	eath	Re	g. No.			
	Dhusisi		Decedent's Name (First, Middle, Last)	_		2. Date of Death	1	Veer	3. Time of	Death
1	Physici /Medic		MELVIN	JAM	ES JR.	DEC Month	Day 5	95	3:39	P.M
	Examir	ner	4a. Facility Name (If not institution, give street and number) 1900 BLK. HOLLINS STREET	B	ALTIMO	ocation of Death	4c. County	of Death		
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthold 217 - 90 - 2738 1)AM 2 F Yrs	Months Dave H	Under 24 Hrs. lours Min.	8. Date of Birth (Month, Day, S€PT. 2	Year) 1977	9. Birthi Coul	place (State o	
	Maryland	ctor	10a. State 10b. County 10c. City, Town or	Location TIMORG	5			1	10d. inside Cit	
	th with the 23a or 28	Funeral Director	10e. Street and Number 2013 Hollins STREET	10f. Zip Code 2122	3	10	og. Citizen of W	hat Cou	ntry?	
0000	d within 72 hours efter death with the Maryland jiane. I than "natural", or flerma 23a or 28a-f show the Modical Examiner must be notified at	by	11. Meritel Stetus 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Wes Decadent Ever in U,S. Armed Forces? 1 Yes, Give Year or Dates:	3. Was Decedent of Hispa It Yes, specify Cuban, N 1 ☐ Yes 2 ☐ No S	nic Origin? (Sp lexican, Puerto pecify:	ecify Yes or No- Prican, etc.)		k, White,	can Indian, etc.	
21215-0020	9 2	Completed	15. Dacedent's Education (Specify only highest grade completed) (GElementary/Secondary (0-12) College (1-4or 5+)	cedant's Usual Occupation ive kind of work done during a. DO NOT use retired)	n ng most of work	ring 1	6b. Kind of Bu	siness/In	duatry	
	高表章其	Be Cor	17. Father's Name (First, Middle, Last)	Student 18.	Mother'a Nam	e (First, Middle, M	laidan Sumami	001		
Maryland		To	MEININ JAMES SR	7	DORIS		0749			
	D # Z		19a Informant's Neme/Relationship (Type, Print) 19b. M 20	ailing Addrass (Straat and	-6 (BAL+			(223	
Baltimore,	of to			sposition (Name of cremetory or other place)	tery 1	Dele 2	Bat	City or To	own, State	
Balt	permit. Peg Department Important: I any Injury o		21. Signature of Funeral Service Licensee	22. Name end Address of LARCH FUR 4300 WG b	Fecility O	tome-		d. ;	2 (2 15	_
			23a. Part. Enter the chasse, or complications that caused the death. Do not shock, or heart talker. List only one cause on each line.			or respiratory arra	st,	1	Approximate interval Bets Onset end D	ween
7	Physician /Medical Examiner		Immediate Cause (Final disease or condition rasulting in death) a. Quishof Qui	not to the	el			1		
		iner	Due to (or as a con	sequance of):	,					
o,	icate be executed physician and s the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediata cause. Enter Underlying	sequence ot):						
Box 68760	nding use at	an/Medicai	Cause (Disease or Injury that Initiated events resulting In death) Last Due to (or as e constant)	sequence ot):						
P.0.	that the ed by th datache	by Physician/I	Pert if. Other significant conditions contributing to death but not resulting in the	a underlying ceuse given in	Part I.		Dacco use con	tribute to		of death? Unknown
Division of Vital Records,	aw requir	Completed b				24a. Was an perform		ev	ere autopsy to aliable prior to emplation of co death?	0
al B	The ate h					1 Yes	s 2 No	1 [Yes 2	No
Z.		o Be	25. Was cese referrad to medicel axaminar? 1 (XYes 2 □ No Hospital: 1 □ Inpatient 2 □ ER/Outoa	Other		h (Check only one		(0	w cmpi	
ion of	Attending Physic death.	\vdash	1 X Yes 2 No	ient 3L DOA	.,	28d. Describe how			STRI	SET_
Divis	s after deat I Director: od in by the	Certification:	3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, building, etc. (Specify)	street, factory, office		28f. Location (Str. City or Town,	eet and Number State)	or or Run	JA Route Num	ber,
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After thi completaly filled in by the funeral	edicai (29a. Certifier (Check only one) 1□ Certifying Phyaician: To the bast of my knowledga, da 2 Nedical Examiner: On the bast of examination and/or and manner stated.	ath occurred at the time, d invastigation, in my opinio	late and place, on, death occur	and dua to the cared at the time, da	use(s) Ind ma ta and place, a		the cause(s	myla
	To th To th Com	Σ	29b. Signeture and title of certifier	29c. License nu			d. Date signed			
	3		30. Nama and address of person who complated ceusa of death ((tem 23a) (Tyr	O.C.N	1.E.	DE	CEMBE	R 6	,1995	
			THEOBORE MIKED 111	Penn Stre	eet, B	altimor	e, Ma	ryla	and 2	1201
	Sta Registr		DEC 1 6 1995 alm d'author la signature							



Pages 1, 2, 3

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funeral director, page 5 should be detached for

completely filled in by the cremation, or removal.

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signed by the attending Health and Mental Hygie

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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH 3. TIME OF DEATH NORMAN **JENNINGS** JR. M DEC 1995 5:05 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH a. BIRTHPLACE (State or Foreig 217-20-9633 MAY 16 MARYI.AND 9e. FACILITY NAME (If not institution, give 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR 2227 W. LEXINGTON STREET BALTIMORE CITY N/A 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? MARYLAND N/A BALTIMORE CITY TY YES 2 NO 10a. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 2227 W. LEXINGTON STREET 21223 IISA 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 X NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No—
If yee, specify Cuban, Mexican, Puerto Ricen, etc.) 14. RACE — American Indien, Black, White, etc. 1 Never Married 2 Married 1 TES 2 NO BY Specify: 3 Widowed 4 Divorced Specify: BLACK 9 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only high Elementary/Secondary (0-12) College (1-4 or 5+) COMPL 7th GRADE TRUCK DRIVER TRUCKING COMPANY 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Meiden Surneme) स्र NORMAN **JENNINGS** BEULAH N. LIVINGSTON notified 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 SHIRLEY KELLY 2227 W. LEXINGTON STREET. BALTIMORE, MD. 21223 must be 20a. METHOD OF DISPOSITION

1 X Burlel 2 Cremation 3 Re
4 Donation 6 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State ARBUTUS CEMETERY ARBUTUS. MARYLAND examiner 21. SIGNATURE OF P VERAL SERVICE LICENSES 22 NAME AND ADDRESS OF FACILITY JOSEPH H. BROWN JR. FUNERAL HOME, P.A. 1913 W. BALTIMORE ST., BALTIMORE, MD.21223 the medical 23. PART I. Enter the diseases, or complications that caused the death. Do not enter tha mode of dying, such as cardiec or respiratory arrest, shock, Dr heart failure. List Dnly one cause Dn each line. Interval Batween OBSTRUCTIVE PULMONARY IMMEDIATE CAUSE (Final Onset and Death disease or condition CHRONIC MONTHS resulting in death) traumatic event. DUE TO (OR AS A CONSEQUENCE OF): CERTIFICATION Sequentielly list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury or other that initiated eventa DUE TO (OR AS A CONSEQUENCE OF): resulting in death) LAST PART II. Other algnificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. MEDICAL 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? PULMONALE PERFORMED: any 1 TYES 2 1 _ YES 2 _ NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one, item HOSPITAL OTHER: 1 YES 2 NO ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 00 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 28b, TIME OF INJURY 28c. INJURY AT 28d. DESCRIBE HOW INJURY OCCURED marked. 1 Natural
2 Accident М 1 YES 2 NO BY 26e. PLACE OF INJURY — At home, farm, street, tectory, office building, etc. (Specify) .00 ETED. 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 8 Could not be 4 Homicide 28 29e. CERTIFIER

Chack COM

CERTIFYINO PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(e) and manner as stated. COMPL TO THE HOSPITAL D
TO THE FUNERAL D
De filed within 72 ho
IMPORTANT: If its (Check only one) 2 MEDICAL EXAMINER: On the besis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 8 29d. DATE SIGNED (Month, Day, Year)

D26395

HURPITAL



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Swit

Fuller

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Brint)

1- 11 M D. BON SECOUR

P. REGISTRAR'S SIGNATURE

12-13-95

BALTIMOR

94-510
ITEN: 23 PART II, Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible, 8245 PER MEO FILM G-731 1/22/96 t.t State of Maryland / Department of Health and Mental Hygiene 3 Certificate of Death 1. Decedent's Name (First, Middle, Last) JOHNNIE 2. Data of Death 3. Tima of Death MAE JORDAN **Physician** DEC 05 Day 1995 11:50 P /Medical 4a. Facility Nama (If not Institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner GEORGE ST. APT# 13 A BALTIMORE CITY If Undar 1 Yaar | If Undar 24 Hrs. Birthplaca (Stata or Foraign Country) 5. Social Security Number 7. Aga (In yrs. last birthday) **Funeral** Months Days Hours 1 M 2 F Yrs. 218-42-0120 Director 50 AUG. 24, 1945 MARYLAND Usuai Rasidanca of Dacedant Pages 1 and 2 should be filed within 72 hours after death with the Maryland neat of Heath and Mental hygiene.
ant: If Item 27 is marked other than "natural", or Items 23s or 28=4 show uny or other transmit or 18 and 18 10a. Stata al Hygiene. i other than "natural", or items 23a or 28a-f show went, the Medical Examinar must be nothfast at 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 X Yas 2 No Director MARYLAND N/A BALTIMORE CITY 10e. Street and Number 10g. Citizan of What Country? 10f. Zlp Code 851 GEORGE STREET, APT. #13 21230 USA. Funeral Was Decedant Evar in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) Race - American Indian, Black, White, atc. 1 ☐ Yas 2 🛣 No If Yas, Giva 1 Nevar Married 2 ☐ Married Baltimore, Maryland 21215-0020 Specify: BLACK 1 ☐ Yas 2 No Specify: ð 3 Widowed 4 Divorced Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) Collaga (1-4or 5+) UNKNOWN HOMEMAKER HOME OWN 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maiden Surnama) Be BUSTER JORDAN SALLTE UNDERWOOD 19e. Informant's Name/Ralationship (Type, Print) 19b. Meiling Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) JUANITA DIGGS 803 COOKS LANE, BALTIMORE, MARYLAND 21229 20b. Placa of Disposition (Nama of cematary, crematory or other place) 20a. Method of Disposition Data 20c. Location - City or Town, Stata 1 Surial 2 ☐ Cremation 3 ☐ Ramoval from Stata permit. Page Department o Important: If any Injury or 12-12-95 MT. ZION CEMETERY BALTIMORE, MARYLAND 4 Donation 5 Othar (Specify) of Funeral Sarvica Licansaa 22. Nama and Addrass of Facility JOSEPH H. BROWN JR. FUNERAL HOME, P.A. 1913 W. BALTIMORE ST., BALTIMORE, MD. 23a. Part1. Entar tha diseasa, or complications that caused tha death. Do not entar tha mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line. Approximata Intarvai Betw Onsat and Death **Physician** /Medical Immediata Causa (Finel Casolovasaler Szess disaasa or condition rasulting in daath) Examiner Examiner or Attending Physician: The law requires that the death certificate be executed burial-transit Sequantially list conditions, if any, laading to immadiate causa. Entar Undarlying Causa (Disaase or Injury that initiated evants rasulting in death) Last Due to (or as a consequence of) physician s the burial Box 68760. Physician/Medical Dua to (or as a consequance of) SBS USB Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. P.0. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown NARCOTIC ABUSE Records, ð ate has been signe page 2 should be 24a. Was an autopsy performed? 24b. Were sutopsy findings available prior to Completed completion of cause of death? 125 Yas 2 □ No certificate Division of Vital Be 25. Was casa rafarrad to medical 26. Placa of Death (Check only ona) Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA XXYas 2□ No Othar: 4 ☐ Nursing Homa XXRasidenca 6 ☐ Othar (Specify) Certification: To this funeral 27. Manufer of Death 28a. Data of injury (Month, Day Year) 28b. Tima of 28d. Dascribe how injury occurred 28c. Injury at Work? After 5 Panding invastigation after death. 1 ☐ Yas 2 ☐ No 2 Accidant 3 Suicida 6 Could not be 281. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Plece of Injury - At home, farm, streat, factory, office building, atc. (Specify) filled in by 4 Homicida 24 hours Hospital 29a, Cartifia 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end piece, end due to the causa(s) and menner as stated. Medical To the Hosp within 24 ho To the Fune completely fi (Check only one) ner: On the basis of axaminetion and/or invastigation, in my opinion, daath occurred at tha tima, data and place, and dua to the cause(s) end-manner stated. 29b. Signature 29c. License number 29d. Data signed (Month, Day, Year) O.C.M.E DEC 06,1995 mpleted cause of death (Nem 23a) (YPE frint) Penn Street, Baltimore, Maryland 21201 30: Name and

State Registra

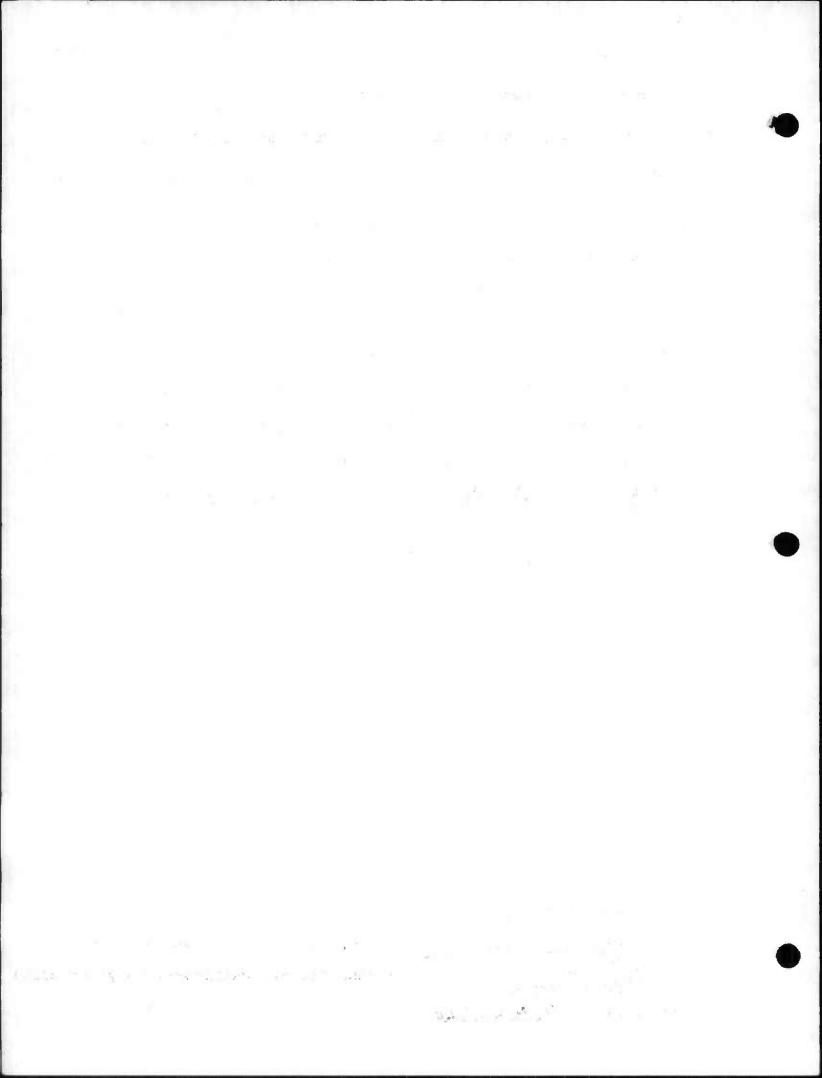
31. Data

th Day Year)

9 1995

32 Registrar's Signature

DHMH 16 Rev 6/95



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

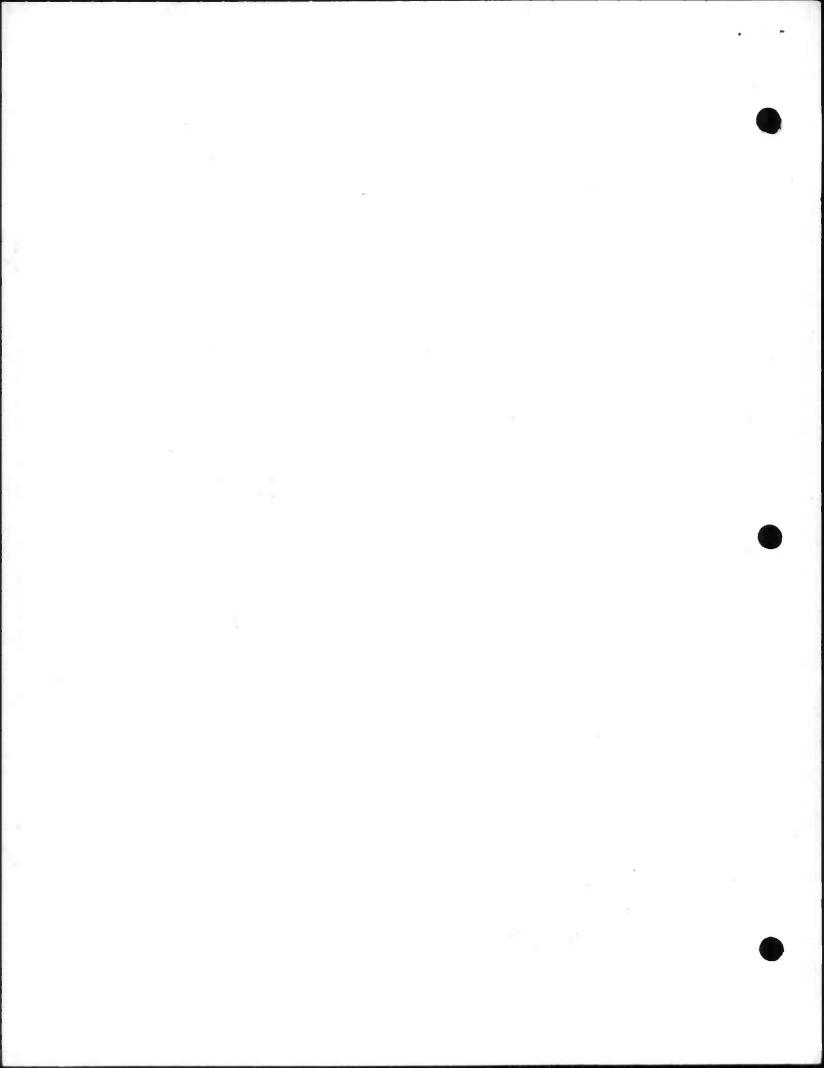
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiens prior to burial, cremation, or removal.

IMPORTANT: If them 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR 1 - STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	HEGISTHAH			ERIIF	ICALE	OF	DEAL	IH .	F	IEG. NO.			
	1. DECEDENT'S NAME (First, Middle, L	CHONG S	SUN KWAK						2. DATE OF MONTH	DEATN DA	Y	YEAR	3. TIME OF DEATN
										19			
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs.	last birthday)	IF UNDER 1	DAYS	HOURS	24 HRS.	7. DATE OF E (Month, De	BIRTH W Mac		a. BIRTN Countr	PLACE (State or Foreign
	219-92-5212	1 □ M 2 F	84	YRS.		UNIO	HOUNS	- WIN.	2/14/				H KOREA
	9e. FACILITY NAME (If not Institution, g	ive street and number)			9b. CITY,	TOWN	OR LOCATIO	ON OF DE	ATN		9c. COU	NTY OF D	
R	FAIRFIELD NURSING H	IOME			CROW	NS7	TIE				ANIME	ADIA T	IDET
DIRECTOR	RESIDENCE OF DECEDENT				CROWNSVILLE						ANNE ARUNDEL		
#	10e. STATE 10b. CO	YTY		10c. CIT	Y, TOWN OF	LOCA	TION						10d. INSIDE CITY LIMITS?
	MARYLAND AN	INE ARUNDEL		HANO	VER								1 YES 2 NO
AL	10e. STREET AND NUMBER					10	. ZIP CODE				10g. CITI	ZEN OF W	THAT COUNTRY?
FUNERAL	7720 MELLOW CT.						21076						
5	11. MARITAL STATUS	12. WAS DECEDEN	IT EVER IN U.S.	ARMED	13. W	AS DEC		F HISPAN	IC ORIGIN? (S	nacify Yes		S. A	- American Indian.
	1 Never Married 2 Married	FORCES? 1	YES 2	ON	14	yes, sp	ecify Cubar	n, Mexican	, Puerto Ricar	n, etc.)	J. 110-	Black	, White, etc.
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≥	17. FATNER'S NAME (First, Middle, Last)	NA NA	l.	IOMEMAK	ER					NN HOM			
							18. MOTN	IER'S NAN	ME (First, Middl	le, Maiden S	Sumame)		
8	DONG IK	KII					BAN			GAE			CHUN
2	19a. INFORMANT'S NAME (Type/Print)		1	19b. MAILING	ADDRESS (Street a	and Number	or Rural A	oute Number, C	City or Town	, State, Zip	Code)	
-	YONG KYU	KWAK	0.00	7720 M	EILOW (CT.	HANOVE	R, M	ARYLAND	21076			
	20e. METHOD OF DISPOSITION 1 □ Burlel 2 □ Cremetion 3 □ F	Samoural from State		E AND DATE		ION (No	me of		DATE	20c. LOC	ATION —	City or To	wn, State
	4 Donation 5 Other (Specify)	Tom State		RTDGE.		AT T	ארוני	11	2/17/95	ביז צים	IDGE.	MADV	בתונה ז
1	21. SIGNATURE OF PUNERAL SERVICE	LIGENSEE		X 1113/			ND ADDRES			13100	1:170,	U BIRT	T-S-MIN
	N X 1 1	A			SIN	GLEI	ON FUN	VERAL	HOME PA	A.			
-					1 S	ECON	D AVEN	TUE S.	W. GLEY	BURN	TIE.	MARYT.	AND 21061
	23. PART I, Enter the diseases, shock, or leart failu	or complications the	t coused the c	deeth. Do r	not enter ti	he mo	de of dyli	ng, auch	aa cardlac	or reapir	atory arr	reat,	Approximate
j)	IMMEDIATE CAUSE (Firm)	to. Clar only one cac	ise on each m	ne.	0								Onset and Deat
1	disease or condition	Can	C 1 10 A 244	. 1	Viene								/1
	reaulting in death)	DUE TO	(OR AS A CONS	EQUENCE OF	Di	-							lyeur
-					. 0								/
CERTIFICATION	Sequentially list conditions, if any, leading to immediate	b. OUE TO	(OR AS A CONS	EOUENCE OF	า:								
Ă	cause. Enter UNDERLYING				•								į
윤	CAUSE (Disease or Injury that initiated events	c. DUE TO	(OR AS A CONS	EOUENCE OF									<u> </u>
F	reaulting in death) LAST				,								İ
8		d											
	PART II. Other significant condi	tions contributing to	death but not	reaulting i	n the und	erlyin	g ceuse g	iven in F	Part I. 24a	. WAS AN A	WTOPSY	24b.	WERE AUTOPSY FINDINGS
EDICAL										PERFORM	-		AVAILABLE PRIOR TO COMPLETION OF CAUSE
									_ 10	YES 2	NO	10.0	DF DEATH?
Σ	DID TOD LOCAL COLUMN												1 TES 2 NO
ž I	DID TOBACCO USE CO						JUNC	ERTAIN					17.7
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	28. PL/	ACE OF OEAT		ly one)							
IS I	1 TES 2 LINO	1 Inputlent 2	ER/Outpatient	3 🗆 DOA	OTHER:	ng Hom	e 5 🗆 Rec	sidence 6	Other (Sp	ecify)			
Ŧ	27. MANNER OF DEATH	28a. OATE OF (Month, D		28b. TIMI	E OF 2		URY AT		26d. DESCRIE	BE NOW IN	JURY OCC	CURED	
BY	1 Natural 5 Pending 2 Accident Investigation		uy, 1001)	113	M		RK? res 2 🗌	NO NO					
	3 Suicide 8 Could not	28s. PLACE O	F INJURY — At I	nome, farm, s	treet, fector	y, office			28f. LOCATIO	N (Street ar	nd Number	or Rural R	oute Number
	4 Homicide datarmine		etc. (Specify)						City or To	wn, State)			
9	29a, CERTIFIER				_	-							
<u>F</u>	(Check only	IYSICIAN: To the best of											
COMPLET		IINER: On the basis of e	camination end/or	r investigation	n, la my opi	nion, d	eath occurs	d at the t	Ime, date and	place, and	due to the	e cause(a)	and manner ea stated.
BE	296. SHOWETURE AND TITLE OF CENTS	FIER					29c. LICE	NSE NUMI	BER		29d. DATE	SIGNED	(Mogth, Day, Year)
	Dichu	My					7 3	898	78	- 1	D/2	2/15	195
유	30. NAME AND ADDRESS OF PERSON	WNO COMPLETED CAUS	SE OF DEATH (IT	EM 27) (Type.	Print)		GP U					+	11-
	DALTEET O	INCH F	INIII			v d A	MIC	10	10 1	Inf	A -	244-	mar 44 0 044
	31. DATE FILED (Month Day Year)	AS DECISTRA	BA SIGNATURE	1410	1/14/	777	くとう	KO	グリキ	100	UD	EN 7	THE OM MO
	DEC1 9 1995	SA REGISTRA	when have	lell						,			
	, and a												





3. TIME OF DEATH

10d, INSIDE CITY

14. RACE — American Indian, Black, White, etc.

Specify: White

1 VES 2 NO

Approximeta

24b. WERE AUTOPSY FINDINGS

AMILABLE PRIOR TO COMPLETION OF CAUSE

1 YES 2 NO

28d. DESCRIBE HOW INJURY OCCURED

281. LOCATION (Street and Number or Rural Route Number, City or Town, State)

interval Batween Onset and Death

8. BIRTHPLACE (State or Foreign

Maryland

Baltimore

Luckert

Est.7:00 P

use as the burial-transit permit. Pages 1, 2, 3 should

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medical examiner

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COMPLETED

BE

2

27. MANNER OF DEATH

Accident

1 Metural

3 Suicide

4 Homicide

and completely filled in by the funeral director,

	5	6	EL.	-
DIVISION OF VITAL RECORDS, P.O. BOX 68760	Mit	ple	9	60
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	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, crema	IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event,

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR 1 -CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH December 16,1995 Stephen Komornik, Jr. Martin 7. DATE OF BIRTH
(Month, Day, Year)
Aug. 1, 1931 A. SOCIAL SECURITY NUMBER 5 SEX 8. AGE (In yrs. last birthday) IF UNDER 1 YEAR | IF UNDER 24 HRS. HOURS 1 💢 M 2 🗌 F 213 26 5278 64 Se. FACILITY NAME (If not institution, give street end number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR 1959 Ewald Ave. Dunda1k RESIDENCE OF DECEDENT 10b. COUNTY 10c, CITY, TOWN OR LOCATION Dunda1k Baltimore Maryland 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10e, CITIZEN OF WHAT COUNTRY? United States 1959 Ewald Ave. 21222 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 XYES 2 NO IF YES, GIVE WAR OR DATES WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No— It yes, specify Cuben, Mexican, Puerto Rican, stc.) 1 Never Married 2 Merried 1 TYES 2 NO Specify: BY 3 Widowed 4 Divorced COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade Elementary/Secondary (0-12) College (1-4 or 5+) Maintenance Mechanic Factory 17. FATHER'S NAME (First, Middle, Lest) 18. MOTHER'S NAME (First, Middle, Meiden Surname) Martin Stephen Komornik, Sr. Bernadette 19e. INFORMANT'S NAME (Type/Print) 19b. MAILINO ADDRESS (Street end Number or Rural Route Number, City or Town, State, Zip Code) 2 1959 Ewald Ave., Baltimore, MD Shirley L. Komornik 20s. METHOD OF DISPOSITION

1

Burlel 2X Cremetion 3

Removal from State 20c. LOCATION — City or Town, State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE Green Mount Crematory 12/19/95 4 Donation 5 Other (Specify) Baltimore, MD 21, SIGNATURE OF UNERAL 22. NAME AND ADDRESS OF FACILITY CAFA Stephen D. Lohrmann P.A. 8717 Green Pastures Dr., Baltimore, MD 21286 Elimeron 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac pr respiratory arrest, ahock, or heart failure. List only one cause on each line. **IMMEDIATE CAUSE (Finel** Mutatatic Carcinara of Colar
DUE TO (OFF AS A CONSEQUENCE OF):

LI Neur Caeleur Chieteca. disease or condition resulting in death) PHYSICIAN: MEDICAL CERTIFICATION Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART ii. Other aigniticant conditions contributing to death but not resulting in the underlying cause given in Part i. 24s. WAS AN AUTOPSY PERFORMED? 1 YES 2 1 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL: OTHER:
4 | Nursing Home 5 Residence 6 | Other (Specify) 1 - YES 2- NO ☐ Inpetient 2 ☐ ER/Outpetient 3 ☐ DOA

29e. CERTIFIER
(Check only one)

2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my policion, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On the basic of examination end/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(e) and manner se stated.

28e. PLACE OF INJURY — At home, term, street, fectory, office building, atc. (Specify)

28b. TIME OF INJURY

29d. DATE SIONED (Month, Day, Year) 29b. SIGNATURE AND TITLE OF CERTIFIER

28c. INJURY AT WORK?

1 YES 2 NO

MIMI

5 Pending

Investigation

8 Could not be

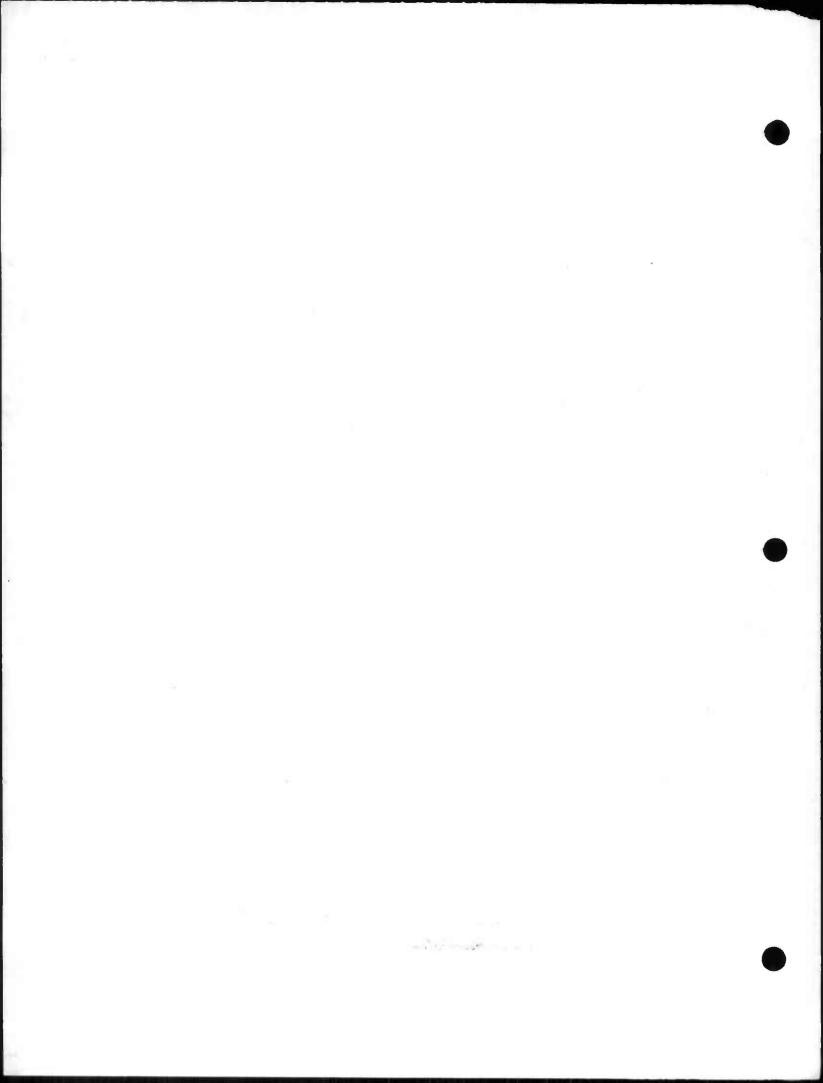
WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

28e. DATE OF INJURY (Month, Day, Year)

Sheldon Milner, M.D. 406 Eastern Blvd, Baltimore, MD 21221

750 RECESTRAT'S SIGNATURE





BALTIMORE, MARYLAND 21215-0020

7

FOR STATE REGISTRAR

1.

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be defached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Merital Hygiens prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH
REG. NO.

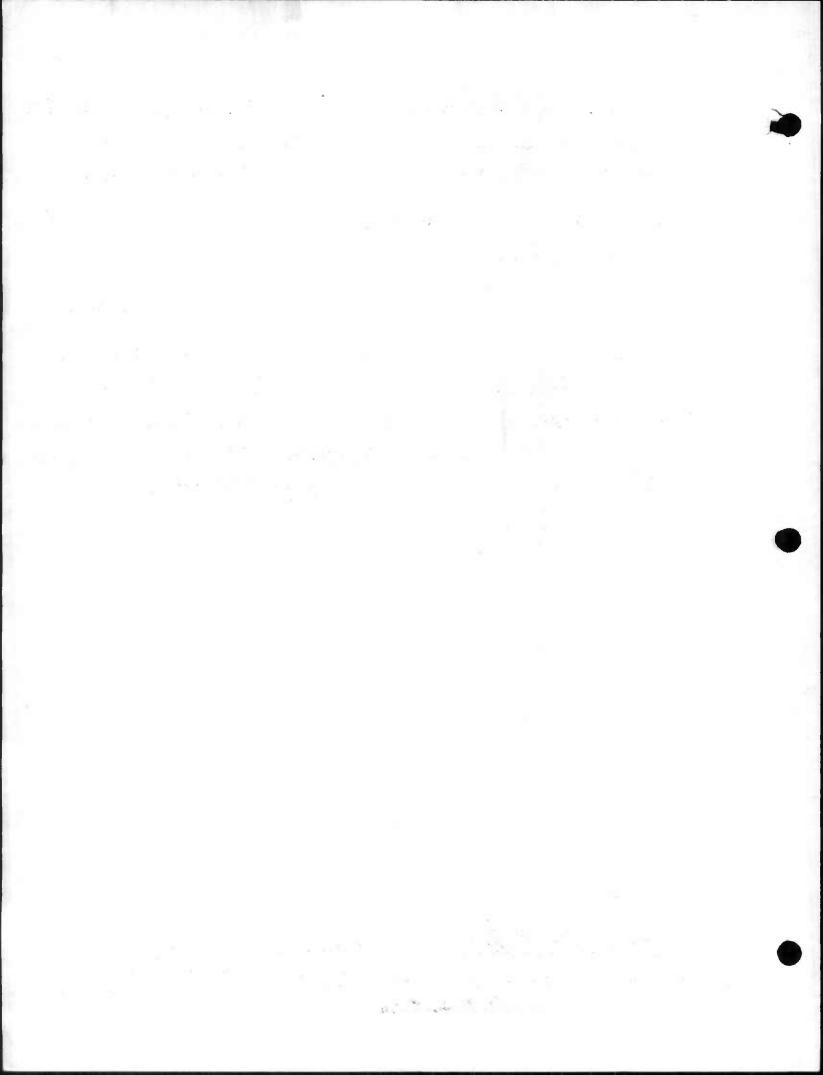
	1. DECEDENT'S NAME (First	t, Middle, Last)					•				TE OF DEATH			3. TIME OF DEATH
	ANN	A	UDREY	Kil	TREL	/				1	Er ,	Y	1995	07:45 PM
	4. SOCIAL SECURITY NUM	BER	5. SEX	6. AGE (in yrs. les	t birthday)	IF UNDER		IF UNDE		7. DA1	E OF BIRTH		9. BIRTHPI	ACF (State or Foreign
	215-30-	-1969	1 🗌 M 2 🔃 F	62	YRS.	MONTHS	DAYS	HOURS	MIN.	AU Z	onth, Day, Year)	33	Country)	Cambridge
	9e. FACILITY NAME (If not institution, give street end number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH											hand		
DIRECTOR	Bayview Medical Center Balto.													
EC	10a. STATE	10b. COUNTY			10c. CIT	Y, TOWN O	R LOCAT	ION	_				T,	IOd. INSIDE CITY
DIR	MD												100	LIMITS?
MD Balto. 10a. STREET AND NUMBER 10g. CITIZEN C												A		
3404 Cotwood Place 21013 USA										SA				
IF VEC ANY MAD OR DATE									NIC ORIG	3IN? (Specify Ye	or No-	14. RACE -	- American Indien, White, etc.	
									0					
		EDENT'S EDU	CATION	100 DE	CEDENTIS	USUAL OC	OUBATIO							Black
COMPLETED	(Specify online Elementary/Secondary (ly highest grade	completed) College (1-4 or 5	(G	ive kind of a Do NOT us	work done o	uring mo	st of worki	ng	13	6b. KIND OF BU	SINESS/IN	DUSTRY	
IP.	12th	J-12)	Conege (1-4 or 5	"	Bar	tend	er				C	afe'		i
Š	17. FATHER'S NAME (First, M	liddle, Last)						18. MOT	HER'S NA	AME (Firs	t, Middle, Maiden	_		
BE	Leroy Ma								W	inni	e Evans	5		
2	19a. INFORMANT'S NAME (.,									imber, City or Tow		Code)	
	Elois Marti			3	3403	Coti	V000	l Pla	ce	Bal	to. Md	. 21	213	
	20a. METHOD OF DISPOSIT		oval from State	cemetery, cre	matory or ol	ther place)				1			City or Town	
	4 □ Donation 5 □ Other 21. SIGNATURE OF FUNERA		ENSEE 1	west	ern	Star		ieter ID ADDRE	_	12/	16/95	Balt	o. Md	
	Tohus.	ODI	TILL	_		Le	roy	0. I	yeti	t &	Son Fui	neral	. Home	
_	CAND	*	1114			460	00 I	iber	ty 1	Hght	s Ave.	Balt	o. Md	. 21207
	23. PART I. Enter the d shock, or h	eart failure	omplications the List only one car	t coused the de se on each line	ath. Don	ot anter	the mo	de of dy	ing, suc	ch aa ca	ardiac or reap	iratory ar	reat,	Approximate Interval Batween
	IMMEDIATE CAUSE (Fundisease or condition		13	h . 1 1	1	1		1		1				Onset and Death
	resulting in death)	→ ,	. Cere	Dra	1as	cul	25	Hec	id &	nt				14 HRS
_		_		PTEN:										14 HRS
CERTIFICATION	Sequentially list condit if any, leading to imme			(OR AS A CONSEC										11 11103
S	cause. Enter UNDERLY	ING	D-											
E	that initiated events resulting in deeth) LAS	*	DUE TO	(OR AS A CONSEC	WENCE OF	ገ :								
H H	rounding in dooring Exc		d						-					
	PART II. Other aignifica	nt condition	s contributing to	death but not r	esulting i	n the un	derlying	ceuse (given in	Part I.	24a. WAS AN			PERE AUTOPSY FINDINGS
MEDICAL	Deep ver	wus	thrombe	USIS ACC	DUIR	ED.	Im	mu	VE		PERFOR		C	MARLABLE PRIOR TO COMPLETION OF CAUSE
ME		cy S	undro	no.				,						F DEATH?
ž	DID TOBACCO U	SE CONTR	RIBUTE TO CA	USE OF DEA	TH YE	S 🗆 N	10 🗵	UNC	ERTAI	NΘ				
PHYSICIAN:	25. WAS CASE REFERRED TO EXAMINER?	O MEDICAL	HOSPITAL:	26. PLAC	E OF DEAT	H (Check o	_							
IXSI	1 TYES 2 NO		1 Inpetient 2			4 Nurs		5 🗆 Re	sidence	6 🗆 Ot	her (Specify)			
	27. MANNER OF DEATH 1 Natural 5	Pending	28e. DATE OF (Month, D		28b, TIMI	E OF URY		RK7	7.00	28d. D	ESCRIBE HOW I	NJURY OC	CURED	
BY	• 🗆 • • • • • • • • • • • • • • • • • •	Investigation	28e, PLACE O	F INJURY — At ho	ne ferm e	treet facto		ES 2 [_ NO	201.17	CATION (Street	and Alexandra		
		Could not be determined	building,	etc. (Specify)	, , , , , , , , ,		ry, orner				ty or Town, State)	ing Numbe	or Hurair Hou	ne Number,
COMPLET	29e. CERTIFIER 1 X CERT	IFYING PHYSIC	CIAN: To the best of	my knowledne de	oth accurre	ed and dhear also								
MP														nd manner ee stated.
111	291 SIGNATURE AND TITLE							29c. LICI						forth, Day, Year)
8	Ve Lut	18	MD					14	811	4		DAT DAT	C CLAR	OK 14 1995
유	30. NAME AND ADDRESS OF	PERSON WHO	COMPLETED CAUS	BE OF DEATH (ITER	1 27) (Type,	Print)		7 1	24,	1		7.00	ENC	TEN AL MITE
	RubertP	e12	MD =	10th NS t	topk.	INS	BAY	VIEL) ME	ED O	TR X	ALTI	2. Mi	0 21224
- 1	31. DATE EN ED /M/DHCDO	Mer) O		R'S SIGNATURE									14 08	
	31. DATE FILED (MDEC	T 9 199	15 11.	A4 .J	A	2								

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 95 38249

				Certificate	or Death	Re	g. No.		
Dhusis	l	1. Decedent's Name (First, Middle, Las	0)			2. Date of Death	-	Year 3. T	ime of Deeth
Physic /Medi		TEREST	A KRAM	IAR		DECEM	35R 15		1:30 P.1
Exami		4e. Facility Name (If not institution, give	street and number)		4b. City, Town, or	Location of Deeth	4c. County	of Deeth	
		925 CARSINS	RUN ROAC	C	ABERDE	2	HA	RFORD	
Funeral		Social Security Number 6. Security Number	7. Age (In yrs.	s. last birthdey) If Under 1 Y Months D	ear If Under 24 Hrs ays Hours Min.		Year)	9. Birthpiace (S	Stete or Forei
Director		218 40 0.121	64	Yrs.	,	JUNEIC		POLAN	0
pur *		Usual Residence of Decedent 10e. Stete 10b. County	10c C	City, Town or Location				10d los	side City Limi
aho a a	7								Yes Z
the N	Director	10e. Street and Number	080	ABEROSSO 101. ZIP CO	d o		- Obles of the		
with a series			00			10	g. Crizen or v	What Country?	
a 23	eral	922 LARSINS	12. Wes Decedent Ever In U		1001	Inneth Van au Na	U . 3	e - American Ind	llaa
s 1 and 2 should be filed within 72 hours after deeth with the Menjand if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Medical Examinar must be notified at	Funeral	11. Maritel Stetus 1 Never Married Married	Armed Forces?	if Yes, specify	of Hispanic Origin? (S Cuben, Mexican, Puerl	to Rican, etc.)		k, White, etc.	ner,
rs af	by F	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1 □ Yes 2012	No Specify:		Specify	1111	-
tura File	P	15. Decedent's Edu		16a. Decedent's Usual O	ccupation	1	6b. Kind of Bu	usiness/Industry	12
n n	Completed	(Specify only highest grad	de completed)	(Give kind of work d	one during most of wo	rking			
with indicate in the	E O	Elementary/Secondery (0-12)	College (1-4or 5+)	MANAGE	1		2HJIH	DAIRY	51080
手	BeC	17. Father's Name (First, Middle, Last)				me (First, Middle, N			O IVIV
S should be filed with and Mental Hygiene. Is marked other than aumatic event, the M	ToB	ACTOR SINE	EDYOCKI		(317)	JA P	IOTRO	AZOG	
should and Men marked umartic	-	19a. Informent's Name/Relationship (T)	ype, Print)	19b. Malling Address (St	9 1	ral Route Number,)
27 le		JOHN KRAMP	54	925 CARSI	ns Run	ROAD	ABERI	1350 C	Japylo
Peges 1 and 2 ment of Health s ant: If item 27 Is ury or other tra		20e. Method of Disposition		Piace of Disposition (Neme of cemetery, cremetory or other	f	Dete 2		City or Town, St	ate
Pege ent o rt: Iff		Burial 2 ☐ Cremetion 3 ☐ if 4 ☐ Donetion 5 ☐ Other (Specify,	Hemoval from Stete	N. S. C.	12 CV	19-18	Bak -	111 Ma	avlas
コモモラ		21. Signature of Funeral Service biomos	iee	22. Name and A	ddress of Fecility	70	LILIAI	112 1 10	NYTHI
Depa Impor		1/015	/		CHAPTIO	- Urwal	BES	C11.	
		23a Part1 Enter the disease or comp	lications that caused the dea	ath. Do not enter the mode of	ARFORD !	COAD -	PARK		vimeto
Physician		23a. Part1. Enter the disease, or comp shock, or heart failure. List only o						tnten	oximate val Between it and Death
/Medical	Ш	Immediate Cause (Final	10-4-	tatic Mel	/	+ Lun	コラルかん	1	12
Examiner	Ш	diseese or condition resulting in death)	a. / VIG . 00 >	(or as a consequence of):	ENOWIA	10 112	0 -		
	je		200101	or as a consequence or.				!	
certificate be executed iding physician and use es the buriel-transit	Examiner	Sequentially list conditions,	b. Due to ((or as a consequenca of):					
e exe		Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury						į	
ate b hysic the b	edical	that initieted events resulting in death) Last	Due to (or as a consequence of):				1	
ing p			d					-	
eath ce attendi for use			u					1	
D 0 D	lan								
0 54	sician	Pert II. Other eignificant conditions co	ntributing to deeth but not res	suiting in the underlying ceus	given in Part t.	23b. Dld tol	sacco use coi	ntribute to the c	ause of dea
of the de d by the a leteched	Physician/	Pert II. Other eignificant conditions co.	ntributing to deeth but not re-	suiting in the underlying ceus	e given in Part t.	23b. Did tol		ntribute to the c	
be de	by	Pert II. Other eignificant conditions co	ntributing to deeth but not rea	suiting in the underlying ceus	given in Part t.	1 🗆 Ye	2 5 No	3 Probably	4 🗆 Unkn
es thet igned b	by	Pert II. Other eignificant conditions co	ntributing to deeth but not rea	suiting in the underlying ceus	given in Part t.		2 2 No autopsy	3 Probably 24b. Were autavellable	4 Unkn
ew requires thet is been signed to 2 should be dete	by	Pert II. Other eignificant conditions co	ntributing to deeth but not rea	suiting in the underlying ceus	e given in Part t.	1 ☐ Ye	2 2 No autopsy	3 Probably 24b. Were autavellable	4 Unkn
The lew requires thet ate hes been signed t page 2 should be dete	by	Pert II. Other eignificant conditions co	ntributing to deeth but not rec	suiting in the underlying ceus	e given in Part t.	1 ☐ Ye	autopsy ed?	24b. Were au aveilable completic of death?	4 Unknown
The lew requires thet ate hes been signed t page 2 should be det		25. Was case referred to medical		suiting in the underlying ceus		1 Ve	autopsy ed?	24b. Were au aveilable completic of death?	4 Unknown
The lew requires thet ate hes been signed t page 2 should be dete	To Be Completed by	25. Was case referred to medical examiner? 1 □ Yes 25 No	Hospital: 1 ☐ Inpatient 2 ☐	□ER/Outpatient 3□ DOA	26. Place of De:	1 Ye	autopsy ed?	3 Probably 24b. Were au aveilable completi of death? 1 Yes	4 Unknotopsy finding prior to on of cause
Physician: The lew requires thet this carificate has been signed b ral director, page 2 should be det	To Be Completed by	25. Was case referred to medical examiner? 1 □ Yes 25 No	Hospital:	□ ER/Outpatient 3□ DOA 28b. Time of Injury 28c.	26. Place of Dea Other: 4 Nursing H	1 Ve 24a. Was an perform 1 Ve	autopsy ed?	3 Probably 24b. Were autaveliable completite of death? 1 Yes	4 Unknotopsy finding prior to on of cause
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or Attending Physician: The law requires that sifer death. Director: After this certificate has been signed E in by the funeral director, page 2 should be deti	Certification: To Be Completed by	25. Was case referred to medical examiner? 1 Yes No 27. Menner of Death 1 Netural 5 Pending Investigation 3 Suicide 8 Could not be determined 29a. Certifier (Check only 2 Medical Exami	Hospital: 1 Inpatient 2 28e. Date of Injury (Month, Dey Year) 28e. Place of Injury - At houiding, etc. (Special Stelan: To the best of my known on the basis of examine	DER/Outpatient 3DDOA 28b. Time of Injury M nome, ferm, street, factory, of if/y) owledge, death occurred at the tion end/or investigation, in recognition of the tion of th	26. Place of Dec Other: 4 Nursing H Injury et Work? 1 Yes 2 No iice iice iie time, date and place ny opinion, death occur cense number	24a. Was an perform 1 Ve ath (Check only one tome SE Resided 28d. Describe hor City or Town, on, and due to the caurred at the time, da	autopsy ed? s 250 No noce 6 Other winjury occurr winjury occurr seet end Numb State)	3 Probably 24b. Were autavellable complete of death? 1 Yes er (Specify) red er or Rurel Route	4 ☐ Unknown topsy finding prior to pn of cause 2 ☐ No
Hospital or Attending Physician: The lew requires thet 44 hours after death. Funeral Director: After this certificate has been signed be tely filled in by the funeral director, page 2 should be det	edical Certification: To Be Completed by	25. Was case referred to medical examiner? 1	Hospital: 1 Inpatient 2 28e. Date of Injury (Month, Dey Year) 28e. Place of Injury - At houiding, etc. (Special Stelan: To the best of my known on the basis of examine	DER/Outpatient 3DDOA 28b. Time of Injury M nome, ferm, street, factory, of if/y) owledge, death occurred at the tion end/or investigation, in recognition of the tion of th	26. Place of Dec Other: 4 Nursing H Injury et Work? 1 Yes 2 No lice lice time, date and place my opinion, death occur	24a. Was an perform 1 Ve ath (Check only one tome SE Resided 28d. Describe hor City or Town, on, and due to the caurred at the time, da	autopsy ed? s 250 No noce 6 Other winjury occurr winjury occurr seet end Numb State)	3 Probably 24b. Were autavellable completic of death? 1 Yes er (Specify) red er or Rurel Route and due to the column as steted.	4 ☐ Unknown topsy finding prior to pn of cause 2 ☐ No
Hospital or Attending Physician: The lew requires thet 4 hours efter death. Funeral Director: After this certificate has been signed be tely filled in by the funeral director, page 2 should be delt	edical Certification: To Be Completed by	25. Was case referred to medical examiner? 1 Yes No 27. Menner of Death 1 Netural	Hospital: 1 Inpatient 2 28e. Date of Injury (Month, Dey Year) 28e. Place of Injury - At h building, etc. (Special Control of the basis of examine and manner stated.	28b. Time of Injury M 28c. Injury M home, ferm, street, factory, offify) owledge, death occurred at the etion end/or investigation, in recognition of the etion end/or investigation.	26. Place of Dec Other: 4 Nursing H Injury et Work? 1 Yes 2 No iice iice iie time, date and place ny opinion, death occur cense number	24a. Was an perform 1 Ve ath (Check only one Standard one Standard one Standard one City or Town, and due to the caurred at the time, da	autopsy ed? s 250 No noce 6 Other winjury occurr winjury occurr seet end Numb State)	3 Probably 24b. Were autavellable completic of death? 1 Yes er (Specify) red er or Rurel Route and due to the column as steted.	4 Unknot topsy finding: prior to pn of cause 2 No

DHMH 16 Rav 6/95



Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible.

State of Maryland / Department of Health and Mental Hygiene

38250 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Yee 9:27AM ALICE KEEFER DEC 1995 18 /Medical 4e. Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner RAVEN FOWSON BALTIMORE MERIDIAN LOCH If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (in yrs. lest birthdey) **Funeral** Months 1 M 2 F Yrs 125-05-2948 76 Director NEW YORK Usual Residence of Decedent 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Examiner must be notified at BALTIMORE PARKVILLE 1 ☐ Yes 2 No Directo MO. 10e. Street and Number 10g. Citizen of Whet Country? MILLOUGHBY PAD.

12. Was Decedent Ever in U.S.

Armed Forces? 6 death with Items 23a 21234 2920 Funeral U.S. A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) Race - American Indien, Black, White, etc. Peges 1 end 2 should be filled within 72 hours after or ment of Health and Mental Hygiene. ant: If Item 27 ie marked other than "natural", or Itel 1 ☐ Yes 2 ☑ No If Yea, Give Year or Detes: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0020 Specify: WHITE 1 ☐ Yes 2 ☑ No Specify: by 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grede complated) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Collega (1-4or 5+) YRS ROPER INC SEAMSTRESS il 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Fether's Neme (First, Middle, Last) Be ANNA 2 LAWRANCE 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Addrass (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Department of Health er Important: If Item 27 is eny injury or other trau PARKVILLE 21234 RO. KEEFER 2920 WILLOUGHBY WILLIAM 20b. Plece of Disposition (Name of cemetery, cremetory or other piece) 20a. Method of Disposition 20c. Location - City or Town, Stete Date 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from State 12-19 4 ☐ Donetion 5 ☐ Other (Specify) BALTIMORE GREEN MOUNT CEM. 22. Neme end Address of Fecility eny ir. MEMORIES OF EVANS CHAPEL 8800 HARFORD RD. 2/12

Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardlac or respiratory arrest, book, or heart failure. List only one cause on each line. 21234 Approximata Interval Between Onset end Deeth Physician /Medical Immediate Cause (Finel disease or condition resulting in death) Examiner Dua to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed burial-transit Sequentially ilst conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Due to (or as a consequence of) Box 68760. physician Physician/Medical the Due to (or as a consequenca of) for use es Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ed by the a 23h. Did tobacco use contribute to the cause of death? Records, P.O. signed by t 1 Yes 2 No 3 Probably 4 Unknown <u>ک</u> 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was en eutopsy performed? Completed page 2 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate Division of Vital director Be 25. Was case referred to medical 26. Placa of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 28a. Date of Injury (Month, Dey Year) 27. Manner of Death 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred After 1 Naturel 5 Pending 1 ☐ Yes 2 ☐ No deeth. 2 Accident i ofter deeth.

Director: A
d In by the fi investigation 8 Could not be Location (Street end Number or Rurel Route Number, City or Town, State) 3 Sulcide 28e. Plece of Injury - At home, farm, atreat, factory, office building, etc. (Specify) 4 Homicida a Funerei Di Funerei Di Dietely filled Ir the Hospital Certifying Physician: To the best of my knowledga, daath occurred at the time, date and piaca, and due to the causa(s) and manner as stated.

| Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and piece, and due to the causa(s) and mennar stated. 29a. Certifier Medical completely (Check only one) within 2 To the 29b. Signeture end title of continue 29c. License number 29d. Date signed (Month, Dey, Year) 30. Nama and addrass of parson who complated cause of death (Item 23a) (Type, Print) HARFORD BD. PARHUILLE 21234 31. Dete filed (Month Day Cear) State Registrar

the one operation of the party of the contract

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

38251 Certificate of Death 1. Decedant's Nama (First, Middle, Last) 2. Date of Deeth 3. Tima of Death Month Year **Physician** 1995 KLINEFELTER DEC WINFIELD -OUIS 10:30 AM /Medical 4a. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PARKVILLE Balto PARKWIND H Under 1 Year H Under 24 Hrs.
Months Days Hours Min.

K Date of Birth (Month, Day, FEB 25) 5. Social Security Number 8. Sax 7. Age (In yrs. last birthdey) Birthplace (State or Foreign Country) **Funeral** 12 M 2□F 80 Yrs. 215-05-8046 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiane.

Int: If Hem 27 is marked other than "natures", or Hems 23s or 28s-f show 10a Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits treumstic event, the Medical Examiner must be notified at Director Baltimore 1 Yas 2 No MA PARKVILL 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 4 PARKWIND 21234 USA Funeral 12. Was Decedent Ever in U,S. Armed Forcas? Was Decedant of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puarto Rican, atc.) Race - Amarican Indian, Bleck, White, atc. 11. Maritel Stetus 1 Navar Marriad 2 Merried Baltimore, Maryland 21215-0020 1 ☐ Yas 2 No Specify: Specify: WHITE by 3 Widowad 4 □ Divorced Completed 16a. Decedent's Usuel Occupation (Giva kind of work dona during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) Collega (1-4or 5+) STATE of Md. DRIVER EXAMINER 12 18. Mother's Nema (First, Middle, Meidan Sumama) 17. Fathar's Nama (First, Middle, Last) Be IDA MAY LENTZ Klinefelter To 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Steta, Zip Code) 19e. Informant's Name/Relationship (Type, Print) Department of Health ar Important: If Item 27 is any injury or other treu once. 4 PARKWIND (Louis W. Klinefelter BALTO. Md 21234 20b. Placa of Disposition (Nama of cemetary, crametory or other plece) 20a. Mathod of Disposition Date 20c. Location - City or Town, State 12/20/95 1 ☑ Burial 2 ☐ Crametion 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Specify) Cedar Hill Cemetery Glen Burnie, Md 22. Nama and Addrass of Facility
22. Nama and Addrass of Facility
EVANS CHAPEL & Memories
8800 Harford Rd, Batto Md. 21. Signature of Funeral Sarvice Licensee EVANS CHAPEL 0 harles Jano 23a. Pert1. Entar tha disaasa, or complications that caused tha daath. Do not antar tha moda of dying, such as cardiac or raspiratory arrest, shock, or haart failura. List only one ceusa on aech lina. Approximata Interval Batween Onset and Deeth **Physician** /Medical Immediata Causa (Final disaasa or condition rasulting in death) home whence CerelHorascular disease Examiner Due to (or es a consequançe of): WITH Yeills or Attending Physician: The law requires that the death certificate be axecuted Sequentially list conditions, if any, leeding to immediata cause. Entar Undarlying Cause (Disaasa or Injury thet initiated evants rasuiting in death) Last Dua to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attanding physiclan for use as the buria Physician/Medicai Dua to (or as a consequence of): signed by the at Id be detached for Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributs to the cause of death? 3 □ Probably 4 ☑ Unknown 1 ☐ Yas 2 ☐ No þ Completed 24b. Wara autopsy findings available prior to 24a. Was an autopsy performed? peen complation of cause of death? page 2 s 1 Yes 2 No 1 ☐ Yas 2 ☐ No certificate 25. Wes case refarred to medical Be 26. Placa of Death (Check only ona) examinar? Othar: 4 □ Nursing Homa Residence 8 □ Other (Specify) Medical Certification: To 2□ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28c. Injury at Work? 27. Mannag of Death 28d. Dascribe how injury occurred 28e. Deta of Injury (Month, Dey Year) 28b. Time of After 5 Panding Invastigation Natural To the Hospital or Attendit within 24 hours after death.

To the Funeral Director: All completely filled in by the fu 1 Yes after death. 2 Accident 3 Suicide 8 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 28a. Placa of Injury - At homa, ferm, straat, factory, office building, atc. (Specify) 4 ☐ Homicida 1 Certifying Physician: To the best of my knowledga, daath occurred at tha time, date end pleca, end due to the cause(s) end manner as steted.

Medical Examinar: On the best of examinetion end/or invastigation, in my opinion, daath occurred et the time, date and place, and due to the cause(s) end manner stated. 29e, Certiflar 29b. Signeture and titla of certifiar 29c. Licanse number 29d. Data signed (Month, Day, Year) J. Crosson Orbondren, M.D 7632 30. Nama and addrass of person who complated causa of death (Itam 23a) (Type, Print) DR. J. Crossan

31. Data filed (Month, De) Lyber 2112 DUNDALK AVE BALTO. Md. 9 199532. Register's stratur State

Registrar



BALTIMORE, MARYLAND 21215-0020

TO BE COMPLETED BY FUNERAL DIRECTOR

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If them 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1 - STATE REGISTRAR	STATE OF MARY			HEALTH AND	MENTAL HYGIENI REG. NO.	E	
1. DECEDENT'S NAME (First, Middle, Lest) JAC	ОВ	HIM	IELFARB		2. DATE OF DEATH DATE DECEMBER	13,199	3. TIME OF DEATH 8:30am M
4. SOCIAL SECURITY NUMBER 212-20-3152	5. SEX 6. AGI	(In yrs. last birthday) 84 YRS.	F UNDER 1 YEAR MONTHS DAYS		7. DATE OF BURTH (Mont. 17, SEPT. 7,19	Co	IRTHPLACE (State or Foreign puntry) ARYLAND
98. FACILITY NAME (If not institution, give s 7202 ROCKLAND HIL		PT. 509		N OR LOCATION OF DE		9c. COUNTY C	
PESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY			Y, TOWN OR LO				10d. INSIDE CITY LIMITS?
MARYLAND 100. STREET AND NUMBER	BALTIMORI	<u> </u>	BA	LTIMORE 101. ZIP CODE		10g. CITIZEN	1 YES 2X NO
7202 ROCKLAND H			13. WAS 0	21209	NIC ORIGIN? (Specify Yea	USA 14 F	AACE - American Indian,
1 Never Married 2 X Married 3 Wildowed 4 Divorced	12. WAS DECEDENT EVER FORCES? 150 YE IF YES, GIVE WAR OR	S 2 NO DATES	If yes,	specify Cuban, Mexica ES 2 X NO Specif	in, Puerio Rican, etc.)		Black, Whita, etc. Specify: WHITE
15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12)		ille. Do NOT u	work done during		166. KIND OF BUS	EDUCATI	
17. FATHER'S NAME (First, Middle, Lest) SAMUEL		MELFARB			ME (First, Middle, Meiden NA	Surneme)	GLICK
19a. INFORMANT'S NAME (Type/Print) MRS JENNIE 20a. METHOD OF DISPOSITION 1 Burlel 2 Cremation 3 Rem	oval Irom State	RB 7202	ROCKLA OF DISPOSITION other place)	ND HILLS	DATE 20c. LO	509 BZ	ALTIMORE, MD
21. SIGNATURE OF TUNERAL SERVICE AN	Truger		SOI 601	AND ADDRESS OF FA LEVINSON O REISTER	& BROS., STOWN ROAD	INC.	
ahock, or hear failure. IMMEDIATE CAUSE (Final disease or condition resulting in dasth)	List only one cause on	each lina.		lymphn		ratory arrest,	Approximata Interval Between Onset and Daeth //6 mas
Sequantially list conditions, if any, leading to immediata cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST	с.	A CONSEDUENCE O					
PART II. Other significant condition					PERFOR	MED?	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH? 1 YES 2 NO
DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL	RIBUTE TO CAUSE	OF DEATH Y		UNCERTAI	N 🗆		
EXAMINER? 1 YES 2N ND	HOSPITAL: 1 inpatient 2 inpati		OTHER: 4 Nursing H		8 Cher (Specify)		
27. MANNER OF DEATH 1 Maturel 5 Pending Investigation	28e. DATE OF INJUR (Month, Day, Year		JURY	INJURY AT WORK?	28d. DESCRIBE HOW I	NJURY OCCURE	D
3 Suicide 8 Could not be 4 Homicide determined	28e. PLACE OF INJU building, etc. (S	RY — At home, larm, pecify)	street, factory, o	ffice	281. LOCATION (Street a City or Town, State)	and Number or Ri	ural Route Number,
one)	ICIAN: To the best of my kn					97	use(a) and manner sa stated,
290. SIGNATURE AND TITLE OF CENTIFIE	is mo	,		29c. LICENSE NU	MBER 729	29d. DATE SIG	SNED (Month, Day, Year)
PAUL CELANO	MO 656		allos St	BAGIR	are no 21	204	
31. DATE FILED (Month, Day, Year) DF C1 9 199	32. REGISTRAR'S SI						

BALTIMORE, MARYLAND 21215-0020

burial-transit permit, Pages 1, 2, 3 should

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within Z4 hours after death, Page 6 may be retained by the hospital or attending	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detaiched for use as the	be filed within 72 hours after death with the State Dept. of Heath and Memal Hygiene prior to burial, cremation, or removal,	IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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										9	5	38253	
	FOR STATE REGISTRAR	STATE OF MAR					EALTH A			GIENE G. NO.			
	1. DECEDENT'S NAME (First, Middle, Last)	NORRIS	KAL	AR					2. DATE OF DE MONTH	17-95	YEAR	3. TIME OF DEATH 5:20 P. M	
	4. SOCIAL SECURITY NUMBER 364-16-4622	5. SEX 8. A	GE (In yrs. leet	birthday) YRS.	IF UNDER	1 YEAR DAYS	IF UNDER 24	HRS.	7. DATE OF BIF (Month, Day,	ITH Year)	Countr	IPLACE (State or Foreign ry)	
E	9a. FACILITY NAME (If not institution, give st MANOR CARE —				9b. CITY,		R LOCATION	N OF OE	04-15 ATH		UNTY OF D	VIRGINIA TIMORE	
2	RESIDENCE OF DECEDENT								DAL	TIMORE			
DIRECTOR	10a. STATE 10b. COUNTY BALTIMORE 10c. CITY, TO							cou	RT			16d. INSIDE CITY LIMITS? t YES XX NO	
FUNERAL	100. STREET AND NUMBER 9603 HEALTHC	LIFF DRI	VE			101.	ZIP CODE 212	237		10g. Cf	U.S	• A •	
BY FUNE	11. MARITAL STATUS 1 Never Married XX Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVI FORCES? 1 1 1 IF YES, GIVE WAR C	YES XXN	MED O	1	f yes, spe		Maxicar	IC ORIGIN? (Spe n, Puarto Rican,		Speci	E — American Indian, k, White, atc.	
ED	15. DECEDENT'S EDUC (Specify only highest grade	CATION completed)	16a. DEC	CEDENT'S	USUAL OC	CCUPATIO	IN st of working		16b. KIND	OF BUSINESS/IN	•	WILLE	
COMPLETED	Elementary/Secondary (0-12) 12 YEARS	College (1-4 or 5+)	life.	Do NOT u	se retired.)		ot or working		A	DVERT	ISIN	G	
S S	17. FATHER'S NAME (First, Middle, Last)						18. MOTHE	R'S NAI	ME (First, Middle,	Maiden Surname)			
BE ((UNKNOWN)								NOWN)				
2	19a. INFORMANT'S NAME (Type/Print)	AD /MIDE								y or Town, State, 2		1000	
	CATHERINE G.KA		20b.PLACE A					· D		TO., MI			
	20a. METHOD OF DISPOSITION 1 Burial 22 Cremation 3 Ram 4 Donation 5 Other (Specify)	oval from Stata	complete cres	metony or o	ther placel			DV	1			.,21202	
	21. SIGNATURE OF FUNERAL SERVICE LIC	CENSEE	GKEER	110		NAME AN	D AOORESS	OF FAC	CILITY				
	N. A.K.						ENRY		. JENK			ONS	
	23. PART i. Enter the diseases, or o	complications that car	veed the dec	eth. Do								MD.21212	
	shock, or heart fellure. IMMEDIATE CAUSE (Final							9,		· roop.na.cory o	,,,	Interval Batween Onset and Daeth	
	disease or condition resulting in death)	omet	=40		131.	10						1	
	resulting in desth)	DUE TO (OR	AS A CONSEC	DUENCE C	F):	C					-		
CERTIFICATION	Sequentially list conditions, if any, leading to immediate	b. DUE TO (OR	AS A CONSEC	DUENCE C	IF):								
S	cause. Enter UNDERLYING CAUSE (Diseese or injury	c.											
	that initiated events resulting in death) LAST	DUE TO (DR	AS A CONSEC	DUENCE C	IF):								
		d											
	PART II. Other significent condition	e contributing to dee	th but not re	esuiting	In the ur	derlying	ceuee gl	ven in		WAS AN AUTOPS	Y 24b	. WERE AUTOPSY FINDINGS MAILABLE PRIOR TO	
100	hyper calc	emia l	00	ne	me	15	-		1	YES XXNO		COMPLETION OF CAUSE OF DEATH?	
Z	- Janen	a ede	~~~	1								1 TYES 2 AO	
AN:	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN												
PHYSICIAN: MEDICAL	25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL: 1 Tyes X NO 1 Tyes X NO 1 Inpettant 2 ER/Outpettant 3 DOA X X Injuryon Home 5 Baaldence 6 Other (Specific)												
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	XX Natural 5 Pending	(Month, Day, Y	ear)	IN	JURY	WO	RK?	NO					
red BY	2 Accident 3 Suicide 6 Could not be datarmined 4 Homicide Could not be datarmined 28a. PLACE OF INJURY — At home, farm, straet, factory, office building, etc. (Specify) 28b. PLACE OF INJURY — At home, farm, straet, factory, office City or Town, State)							Route Number,					
COMPLET	29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINE	ICIAN: To the best of my										a) and manner as stated.	
BE CO	29b. SIGNATURE AND TITLE OF CERTIFIE						29C LICEN				ATE SIGNED) (Month, Day, Year)	
0	30 NAME AND ADDRESS OF PERSON WH	IO COMPLETED CALLES	E DEATH ATT	4 970 /5	- Deigo		1	11	107		12-	18-95	

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) HOUCK M.D., 7825 YORK ROAD, TOWSON, MARYLAND

32. REGISTRAR'S SIGNATURE

32. REGISTRAR'S SIGNATURE THEODORE A.

31. DATE FILED (Month, Day, Your 9 1995



use at the burlat transit permit. Pages 1, 2, 3 should

attending physician.

21215-0020

BALTIMORE, MA

AL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours	AL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the	2 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal
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DIVISION OF VITAL RECORDS, P.O. BOX 68760

	FOR STATE REGISTRAR	STATE OF MARYLANI		ITMENT OF F		MENTA	REG. NO.			
	1. DECEDENT'S NAME (First, Middle, Last)						OF OEATH		3. 1	TIME OF OEATH
	BETTY	Н.		KRA	MER	DEC	EMBE			9:30 PM
	4. SOCIAL SECURITY NUMBER 5.	SEX 6. AGE (In yrs	s. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE	OF BIRTH	8.	BIRTHPLA	CE (State or Foreign
	219 105655 1	□ M 2 🗗 79	YRS.	MONTHS DAYS	HOURS MIN.		ust 8,			yland
_	9a. FACILITY NAME (If not institution, give street			1	OR LOCATION OF DE			9c. COUNTY		1
6	Good Samaritan Hos	spital		Baltimo	ore , Cit	.y			I/A	
DIRECTOR	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY		10c, CIT	Y, TOWN OR LOCA	TION				100	. INSIDE CITY
E	Maryland N/	Δ	Ra	ltimore	City				1.8	LIMITS?
	10e. STREET AND NUMBER		1 00		. ZIP CODE			10g. CITIZEN	^	
FUNERAL	1632 Roundhill Road	d			21218			- 11	S.A.	
S		. WAS DECEDENT EVER IN U.S.	ARMED		ENDENT OF HISPAI				RACE -	American Indian,
BY F	1 Never Married 2 Married 3 Wildowed 4 Divorced	FORCES? 1 YES 2	XINO		ecify Cuben, Maxica 2 X NO Specif		Rican, etc.)		Black, WI Specify:	
										White
COMPLETED	15. DECEDENT'S EDUCATI (Specify only highest grade con		(Give kind of a life. Do NOT us	Work done during me	ON est of working	16b	. KINO OF BUS	INESS/INDUS	RY	
١٣	Elementary/Secondary (0-12)	College (1-4 or 5+)	Cler	,			Stata	of Ma	מועמ	nd D M V
N N	17. FATHER'S NAME (First, Middle, Last)		crei	K	18. MOTHER'S NA	ME /First			Гута	nd D.M.V.
	Antonio Kramer					- 1	hiemey			
BE	19a. INFORMANT'S NAME (Type/Print)		19b, MAILING	ADDRESS (Street	and Number or Rural		-		de)	
임	Miss Valeria M. Kı	ramer		Same a						
	20a. METHOD OF DISPOSITION	20b. PLA		OF DISPOSITION (N	ame of	OAT	E 20c. LO	CATION — City	or Town,	State
	1 Surial 2 Cremation 3 Remova 4 Donation 5 Other (Specify)	Par	kwood	Cemetery	12/	/18/9	5 Bal	timore	. Ma	ryland
	21. SIGNATURE OF FUNERAL SERVICE LICENS			22. NAME A	and J. F	CILITY	Funora	1 Home	In	C
	Wonald Co Sela	14 1/2		530	Harford	l Rd	Ralti	MORE	Mary	land 21214
	23. PART I. Enter the diseases, or con	plications that caused the	e deeth. Do i							Approximate
	shock, or heart feliure Lis	•								Interval Between Onset and Daath
	disease or condition resulting in death)	HYPOTEN	SIVE	FI	ICEPH	HAL	OPA	THY	/	7 Day
	readiting in death)	DUE TO (OR AS A COI	NSEOUENCE O	F):						7 200/5
Z	C b.	A CU-	TE	MYOC	ARDIA	(1	NFAI	IT DS	ino	7 DAYS
E	Sequentially ilst conditions, if any, leading to immediate	DUE TO (OR AS A CO	NSEQUENCE O	F):						720
2	cause. Enter UNDERLYING CAUSE (Disesse or injury	DUE TO (OR AS A COI								+ DAYS
Ē	that initiated events resulting in death) LAST	DOE TO (OR AS A COR	NSECUENCE O	er j.					j	
CERTIFICATION	d									
CAL	PART II. Other aignificent conditions of	ontributing to death but n	ot resulting	in the underlyin	g cause given in	Part i.	24a. WAS AN PERFOR			RE AUTOPSY FINDINGS
8							1 TYES 2	No	COI	MPLETION OF CAUSE DEATH?
ME									1 [YES 2 NO
ż	DID TOBACCO USE CONTRIB				UNCERTAI	Ν□				
PHYSICIAN: MEDI		IOSPITAL:		TH (Check only one,						
IYS	1 YES 2 NO 1	Inpetient 2 ER/Outpetier		4 - Nursing Hor	ne 5 🗆 Realdenca					
	1 Netural 5 Pending	26a. OATE OF INJURY (Month, Day, Year)	26b. TIN	JURY W	JURY AT DRK?	28d. DE	SCRIBE HOW II	NJURY OCCUR	ED	
B	2 Accident Investigation	28a. PLACE OF INJURY — A	li home form		YES 2 NO	200 1 00	ATION (Street a		0 / 0 /	
	3 Suicida 6 Could not be 4 Homicide determined	building, atc. (Specify)	e nome, term,	atreet, factory, one	:•		or Town, State)	ng Number or	HURN HOUR	Number,
9	29a. CERTIFIER									
MP	(Check only	N: To the best of my knowledge								
COMPLETED		On the basis of examination en	G/OF Investigation	on, in my opinion,			and place, an			
BE	296. SIGNATURE AND TITLE OF CERTIFIER	ME M	. 0		DA9 2					onth, Day, Year)
ē	30. NAME AND ADDRESS OF PERSON WHO C	OMBI ETEO CALISE OF DEATH	//TEM 277 /5:	Drint)	P093		_			ER 15, 1995
	DR NEER I GUS	STA CONT	C A A	AA OFTA	N Haco	TO.	5601	LOCH	-1 RM	MD FISSO
	31. DATE EILED WORK DEW YORK	32 REGISTRAR'S SIGNATU	RE JAIC	HKIA	14 LIO261	THE	BAI	TIMO	REI	WD 51532
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DIVISION OF VITAL RECORDS, P.O. BOX 68760

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L DIF	s more within 12 thought with the control of the co
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THE	POOP
	3. THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 and a feet of the state and the sixth and labeled Husians prior in burial primation or among the funeral primation or among the function of the function o

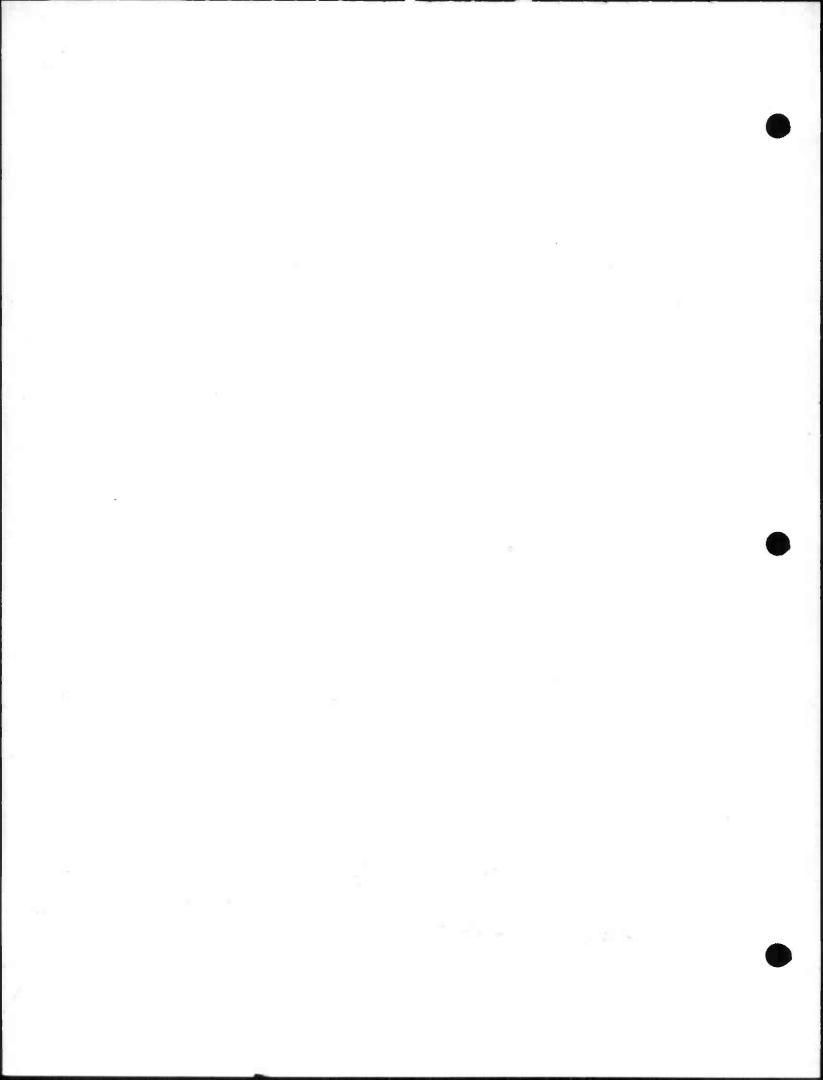
FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH Lhas 14 DEC 7:15A 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH (Month, Day, Year, SEPT. 8. BIRTHPLACE (State or Foreig IF UNDER 1 YEAR IF UNDER 24 HRS. 2-28-0984 1 - M 2 AF DAY8 HOURS 9e. FACILITY NAME (If not institution, give street and number) 9b, CITY, TOWN OR LOCATION OF DEATH COUNTY OF DEATH HERRYWOOD ACTIMORE DIRECTOR ALTIMORE RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 18c. CITY, TOWN OR LOCATION 10d. INSIDE CITY AG 1 YES 2 NO BALTIMORE 10e. STREET AND NUMBER FUNERAL 101. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 3313 OGES 21215 HVG 4CD 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No—If yee, specify Cuban, Maxican, Puerto Rican, etc.)

1 YES 2 NO Specify: 11. MARITAL STATUS 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Married Spootly: Black BY 3 Widowed 4 Divorced ETED 16e. OECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life, Do NOT use retired.) 15. OECEDENT'S EDUCATION secify only highest grade comple 16b. KIND OF BUSINESS/INDUSTRY College (1-4 or 5+) COMPL MOSPITAL touse kee Per NA 17. FATHER'S NAME (First, Middle, Last) te. MOTHER'S NAME (First, Middle, ANDIE BE 19a. INFORMANT'S NAME (Typo/P) 5 20a. METHOD OF DISPOSITION
t Burial 2 Cremetion 3
4 Donation 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of 200 LOCATION - City or Town, State DATE 12-16-05 EMA TOPO 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY UNGEAL LARCH 51512 00 23. PART I. Eyer the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, suck, or heart failure. Liet only one cause on each line. Approximete Interval Between IMMEDIATE USE (Final disease or condition resulting in seath) Onset and Death ASPIRATION 1 DA' DUE TO (OR AS A CONSEQUENCE OF) CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate ceuse. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF) that initiated evente resulting in death) LAST PART II. Other algnificant conditions contributing to deeth but not resulting in the underlying cause given in Part i. PHYSICIAN: MEDICAL 24s. WAS AN AUTOPSY 24h WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE PERFORME 1 TES 2 OF DEATH? 1 | YES 2 | DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 28. PLACE OF DEATH (Check only one) 25. WAS CASE REFERRED TO MEDICAL EXAMINER? Nursing Home 5 Residence 6 Other (Specify) HOSPITAL:
1 | Inpatient 2 | ER/Outpatient 3 | 1 TYES 🔪 27. MANNER OF DEATH 20e. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED Natural 5 Pending Investigation 1 YES 2 NO В 2 Accident 3 Suicide 28s. PLACE OF INJURY — At home, farm, street, fectory, office building, atc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 29a. CERTIFIER CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and piece, and due to the cause(s) and menner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29d. DATE SIGNED (Month, Day, 8 HO WAR 221680 re.

FD CAUSE OF DEATH (ITEM 27) (Type, Print

100

PARK HELLHIS AVE



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 95

						Cen	tificate of	Death		Reg. No.		
	Physic	ian	Decedent's Neme (First, Middle,				1 - 2 - 6		2. Dete of De Month	-	9 9 5	3. Time of Death 5:07 P.M
	/Medi		As Estilla Name (Marchine)	Haskell		Litt	lejohn	th City Town	Dec			0.07 1.11
7	Exami	ner	4e. Fecility Neme (If not institution, Liberty Medi	the second second				4b. City, Town, or Baltim		h 4c. County	N/A	
	Funeral Director		5. Sociel Security Number 247 – 28 – 4762	Sex 7. Ac	ge (In yrs. las	st birthdey) Yrs.	Months Deys		. (Month, D	rth ey, Year) 1918	9. Birthpl Count	ece (State or Foreign S.C.
	pu *		Usuel Residence of Decedent 10e. Stete 10b. County		100 City	Town or Loc	ation			,	40	ad testide On a timbe
	e Maryia Ba-f sho	ctor	MI	I/A		ltimor						od. inside City Limits 1 X Yes 2 □ No
	th with th	Funeral Director	10e. Street and Number 2470 Keyworth A	venue			10f. Zip Code 21215	Ö		U S A	Whet Count	ry?
020	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Itam 27 is marked other than "naturel", or items 23a or 28a-f show any Injury or other traumatic event, the Modical Examines must be notified at Angle.	by	11. Maritel Stetus 1 Never Married 3 Married 3 Widowed 4 Divorced	12. Wes Decedent Armed Forces? 1 Yes 20 If Yes, Give Yeer or Detes:		if	Vas Decedent of Yes, specify Cu ☐ Yes 2X No	Hispenic Origin? (ben, Mexicen, Pue	Specify Yes or Norto Ricen, etc.)		ck, White, e y: Bla	etc.
2-0	72 ho	ted	15. Decedent's	Education		18e. Decede	ent's Usuei Occu	pation	a dela a	16b. Kind of B	usiness/Ind	ustry
d 21215-0020	filed within Hygiene.	e Completed	(Specify only highest Elementery/Secondery (0-12) 6th grade 17. Fether's Neme (First, Middle, La	College (1-4or	5+)	life. D	ane Ope	erator	orking ome (First, Middle	Steel , Meiden Sumar	ne)	
lan	d be ental ked c	To Be	Joe Littlejoh	n				Mary	Good			
Maryland	M M M	-	19e. Informent's Name/Reletionship			19b. Meliing	Address (Stree	et end Number or F		per, City or Town	State, Zlp	Code)
	nd 2 alth a 27 is r tra		Christine Littl	ejohn				th Avenue		-		
Baltimore,	Pages 1 a ent of Heam nt: If Itam y or othe		20e. Method of Disposition 1 Burial 2 Cremetlon 3 4 Donetion 5 Other (Spe		cen	netery, crem	ition (Neme of etory or other pl Cemeter)	*	Dete 121895	20c. Location Lansdo		
Balti	permit. I Departm Importar any injui		21. Signeture of Funerel Service Lla			22.	Name end Addi				,	
			23a. Pert 1. Enter the disease, or conshock, or heart feiture. List or	Colmo	nd		1300 Wa	abash Ave	nue Balt	o, Md	21215	Approximate
	Physician /Medical Examiner	ner	immediate Cause (Finel disease or condition resulting in deeth)		Due to (or e	IRA-	TORY Jence of):	FAI	LURE	na 3	and W 1	Interval Between Onset and Death
68760,	eath certificate be executed attending physiclan and for use as the buriel-transit	Medical Examiner	Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that intireted events resulting in death) Last	b	Due to (or e	s e consequ	ence of):	770007		0,0,0,0		//) <u>F</u> 1) <u>F</u> 1
×	onding use a			d								
. Bo	0 0 0	Sicla	Pert II. Other significant conditions	contributing to death b	ut not resulti	ing in the unc	deriving cause o	iven in Pert I.	23b. Did	tobacco use co	ntributa to	the cause of death?
, P.O	signed by the	by Physician							. 1	Yss 2□ No	3 Prob	ebly 4□Unknown
Records,	aw requisite pendents should	Completed b								s an autopsy ormed?	ave	re autopsy findings illeble prior to apletion of cause leath?
3	The ate h	0							10	Yes 2 No	1 🗆	Yes 2□ No
Vital	ysicien: The s certificate director, per	Be	25. Wes cese referred to medical exeminer?					26. Place of De	eth (Check only	one)		
of V	5 00	ည	1 Yes 2 No	Hospitei: 1 Inpatio	ent 2 EF	2/Outpatient	3□ DOA O	ther: 4 D Nursing	Home 5 ☐ Res	idence 8 Oth	er (Specify)
	P P		27. Menner of Deeth 1 Neturel 5 Pending 2 Accident investige	28e. Dete of Inju (Month, De	iry Year) 2	8b. Time of Injury	28c. Inju W M 1 [ury et ork?] Yes 2 No	28d. Describe	how injury occur	red	
Division	To the Hospital or Attending is within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Certification:	3 Sulcide 8 Could no determine	286. Place of in	ury - At hom c. (Specify)	e, ferm, stre	et, fectory, office	-		(Street end Num wn, Stete)	ber or Rurel	Route Number,
	To the Hospital or within 24 hours after To the Funeral Dirticompletely filled in	edical	29a. Certifier (Check only one) 1 **Certifying 2 ** Medical Ex	Physician: To the best aminer: On the basis o end menner st	f examinetion	edge, deeth on end/or inve	occurred et the t estigation, in my	time, date end pled opinion, deeth occ	e, and due to the curred et the time.	ceuse(s) and m dete end piece,	enner as ste and due to	eted. the cause(s)
	To t	Σ	29b. Signeture end title of certifier				29c. Licer	nse number	,	29d. Date signe	d (Month, E	lay, Year)
	10		Darrich 30. Neme end eddress of person wh	Silver	DO leeth (Item 2	3e) (Tyne P	H 4	13234	1	Decen	ber	18,1995
	1		3411 BAN	KST	BA	2 T / M	YORE	MD	2122	4		
	Sta	te	31. Date filed (Month, Dey, Year)	32. Registr	ar's Signetur	е	L! /					

the sale of the sa BALTIMORE, MARYLAND 21215-0020

ITEM: 19a, PER F.H. FILM g-730 12/28/95 tt

ITEMS: 7.10c.10d. 1 per f.h. film G-730 12/19/95 t.t

	DECEDENT'S NAME (First, Middle,						2. DATE	OF DEATH	YEA		OF DEATH
	STANLEY, L	LUNTZ					DEC	EMBELIS	95		:35 P
473	214-26-5446	5. SEX 1, ⊠ M 2 □	6. AGE (In yrs.	last birthday) 5 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HR	7. DATE	OF BIRTH 193	0 8. B	HRTHPLACE (S ountry) Marylan	state or Foreign
90.	. FACILITY NAME (If not institution,	, give street and number)		9b. CITY, TOWN	OR LOCATION OF	DEATH	9	c. COUNTY		
RE	MERCY MEDICA	YL CENTER	ζ		BALTII	MORE			CITY		
	M10013	Baltimore			Y, TOWN OR LOC	RAND	LLSTON	IN		LIM	BIDE CITY AITS? ES ZV NO
	e. STREET AND NUMBER	attrilore		10.2		IOI. ZIP CODE		1	0g. CITIZEN	OF WHAT COL	4317
8	8714 Allenswoo	od Rd				21133			U.S	5.A.	
1[. MARITAL STATUS Never Married 2XXMerried Wildowed 4 Divorced	FORCES? IF YES, GI	EDENT EVER IN U.S. 1 YES 2 VE WAR OR DATES	ARMED NO	It yes,	ECENDENT OF HIS specify Cuben, Me ES 2XXNO Sp	dcan, Puerto	N? (Specify Yes or Rican, stc.)	100	RACE — Amer Black, White, of Specify:	ricen Indien, etc.
	15. DECEDENT' (Specify only highes	'S EDUCATION	Korea 16a.	(Give kind of 1	USUAL OCCUPA work done during	TtON most of working	16	b. KIND OF BUSIN	ESS/INDUSTI		100
	Elementary/Secondary (0-12)	College (1-4	or 5 +)	Chauf		- 3		Taxi	Cab		
17.	FATHER'S NAME (First, Middle, La	nst)				18. MOTHER'S	NAME (First,	Middle, Maiden Sui	name)	100	- M
	Morris		Luntz				ra	. (1)		nyder	
194	e, INFORMANT'S NAME (Type/Print							mber, City or Town, S			
P	Mrs. Shirley &	Enyder LUN	1					allstown			
120	be. METHOD OF DISPOSITION Burlet 2	Ramoval from Stat	 cemetery. 	crematory or o						or Town, State	
	Signature of Funeral Series		— I Bal	timore	Hebre	AND ADDRESS OF	2/17/	951 Re	sters	stown,	MD
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4	Toll	D Cr									
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		ea, or complications aliure. List only one								Aj In	pproximate iterval Betw
iN	ahock, or heart fa MMEDIATE CAUSE (Final lisease or condition	allure. List only one	cause on each	ilne.	not enter the					Aj In	pproximate iterval Betw
iN	ahock, or heart fa MMEDIATE CAUSE (Final	allure. List only one		ilne.	not enter the					Aj In	pproximate iterval Betw
ilV di re	ahock, or heart fa MMEDIATE CAUSE (Final lisease or condition	allure. List only one	volvo (E TO (OR AS A CON J Hi O	line. Le prince of the second	fruitor					Aj In	pproximate iterval Betw
ilV di re	ehock, or heart fa	a. Cu	volvo (E TO (OR AS A CON J Hi O	ISEQUENCE O	frestor					Aj In	pproximate iterval Betw
Self of the re	ehock, or heart fa	a. Cu Du c. Du d.	E TO (OR AS A CON	ISEOUENCE O	frator	stem Falx	Mer fai	hve	lory arrast,	Aj in Ori	pproximate nterval Between and De
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TO THE HOSPITAL, OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hos	TO THE FUNERAL, DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detach:		IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.
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1	cate	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	Item
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TO BE COMPLETED BY

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	FOR 1 - STATE REGISTRAR	STATE OF I	MARYLAND /		RTMENT					HYGIEN REG. NO.	-				
	1. DECEDENT'S NAME (First, Middle, Last)		- 0.	_,,,,,,	IOAIL	. 01	DEA		2. DATE OF			_	2.70	ME OF DEAT	TM.
,	ROBERT	E.		LEU	JTBEC	HER			MONTH Dec.	13		YEAR 995	5	-30	. м
	4. SOCIAL SECURITY NUMBER	t birthday)	IF UNDER		IF UNDER	24 HRS.	7. DATE OF			8. BIRT	HPLAC	E (State or Fo	reign		
	219-07-1548	75	YRS.	MONTHS	DAYS	HOURS	MIN.	Jan.		920	Mary	.,	nd		
	9s. FACILITY NAME (If not institution, give st		9b. CITY, TOWN OR LOCATION OF DEATH					J		INTY OF					
<u>د</u>	Stella Maris				т	owso	m				D.	.1+4-	m o		
K	RESIDENCE OF DECEDENT					01130	/11				Do	altin	HOL	2	
DIRECTOR	10s. STATE 10b. COUNTY	r			Y, TOWN O		ION						10d.	INSIDE CITY	
ā	Maryland n/a			Ba	altim	ore								YES 2	NO
A	10e. STREET AND NUMBER					101	ZIP COD	E			10g. CI1	TIZEN OF	WHAT	COUNTRY?	
FUNERAL	1014 E. Lake Ave	2.				1 2	21212	2			U.S.	.A.			
5	11. MARITAL STATUS	12. WAS DECEDEN	IT EVER IN U.S. AR		13.	WAS DEC	ENDENT (OF HISPAI	NIC ORIGIN?	Specify Yes	or No-	14. RAC	E A	merican India	an,
	1 Never Married 2 Married	FORCES? 1	MAR OR DATES	40			2 X NO		en, Puerto Ric	an, etc.)		Spec		in, atc.	
В	3 Widowed 4 Divorced	IF YES, GIVE V	/ II				24	opoon	,			Wh:	ite		
COMPLETED	15. DECEDENT'S EDUC (Specify only highest grade	CATION	16a, DE	CEDENT'S	USUAL O	CCUPATIO	N of works	nd.	16b. K	IND OF BU	SINESS/IN	DUSTRY			
E I	Elementary/Secondary (0-12)	College (1-4 or 5	+) ille	Do NOT u	work done (se retired.)	auring mo	St OF WORKS	''y							
鱼	12 yrs		Po.	lice	Offi	cer			Ba	altim	ore (City			
ő	17. FATHER'S NAME (First, Middle, Last)						16. MOT	HER'S NA	ME (First, Mic	ldle, Maiden	Surname)				
BE	Walter E. Leutbec	cher					Jι	ılia	V	<i>lyers</i>					
	19a. INFORMANT'S NAME (Type/Print)		19	b. MAILING	ADDRESS	(Street a	nd Numbe	r or Rural	Route Number	City or Tow	n, State, Z	ip Code)			
2	Kathleen Laudema	an		2219	West	ride	ge Ro	d. T	imoniu	m, M	d. 2	1093			
1	20a. METHOD OF DISPOSITION		20b. PLACE	ANDDATE	OF DISPOS	SITION (Ne	me of		DATE	20c. LO	CATION -	- City or Town, State			
	1 Donation 5 Other (Specify)	oval from Stala	cemetery, cre	dge Cemetery 12-16 Pikesville, M						Md					
	21. SIGNATURE OF FUNEBAL SERVICE LIC	CENSEE			22.	NAME AF	D ADDRE	SS OF FA							
			11						Funera						
	no name i E-a-a de disease es								Tows				4		
	23. PART I. Enter the diseases, or c shock, or hasrt failure.				not enter	the mo	de of dy	ing, suc	ch aa cardia	c or reap	iratory a	rreat,		Approxim	
	IMMEDIATE CAUSE (Final									L	417	1		Onset and	d Death
	disease or condition resulting in death)	· A	RC (NO)	41	OF	4	ZFT	H	IDNE	4 6	1EM	TACE	-	21	Year
		DUE TO	(OR AS A CONSE	QUENCE C	OF):						417				
N	Sequentially list conditions,	b													
Ĕ	If any, leading to immediate cause. Enter UNDERLYING	DUE TO	(OR AS A CONSE	QUENCE C	NF):								ļ		
ERTIFICATION	CAUSE (Disease or Injury	C. OHE TO	(OR AS A CONSE	OLIENCE C	ME).										
Ē	that initiated eventa resulting in death) LAST	502 10	(on AS A CONSE	GOENOL C	n y.								j		
CEF		d											+		
	PART II. Other significant condition	s contributing to	dsath but not	rssulting	In the ur	ndarlyln	csuss	givan in	Part I. 2	4a. WAS AN		24		E AUTOPSY F	
MEDICAL	MRTENOSCEN	OTIC	CHARD	104	MSC	ULI	977	DIS	BLE	PERFOI			COM	PLETION DF	
	9								(3/2		100			EATH?	NO
	DID TOBACCO USE CONT	RIBLITE TO CA	AUSE OF DEA	TH Y	ES 🗆 I	NO P	LINI	CERTAI	ND				. []	YES 2 1	NO.
AN	25. WAS CASE REFERRED TO MEDICAL	TO CA			TH (Check		. 0111		., _						
2	EXAMINER? 1 YES 2 WO	HOSPITAL:	ER/Outpatient 3		OTHE	R:		-14		D					
PHYSICIAN:	27. MANNER OF DEATH	26a, DATE O		28b. Til		28c. INJ		esidence	6 Other (Specify)	N.IIIev ~	CCUPED			
	1 Metural 5 Pending		Day, Year)		JURY	WC	RK?	NO.	200. 0230	HOW		JOUNED			
ВУ	2 Accident Investigation	26s. PLACE	OF INJURY At he	ome, form	street fact				281 LOCAT	ION (Street	and Numb	er or Dive	/ Flourite	Number	
0	3 Suicide 6 Could not be	building	, atc. (Specify)			,, 01110	-			Town, State,		u. ur raurez	. 10010	r mourt,	

1 CERTIFYING PHYSICIAN: To the best of my knowledge, dasth occurred at the time, data and place, and due to the cause(a) and manner as stated.
2 MEDICAL EXAMINER: On the bests of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and manner as stated.

29c. LICENSE NUMBI

29c. LICENSE NUMBI

D/2/

Dr. Walter Welzant 7600 Osler Dr. Towson, Md. 21204

31. DATE FILED (Mong) 1995) 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day.

6 Could not be determined

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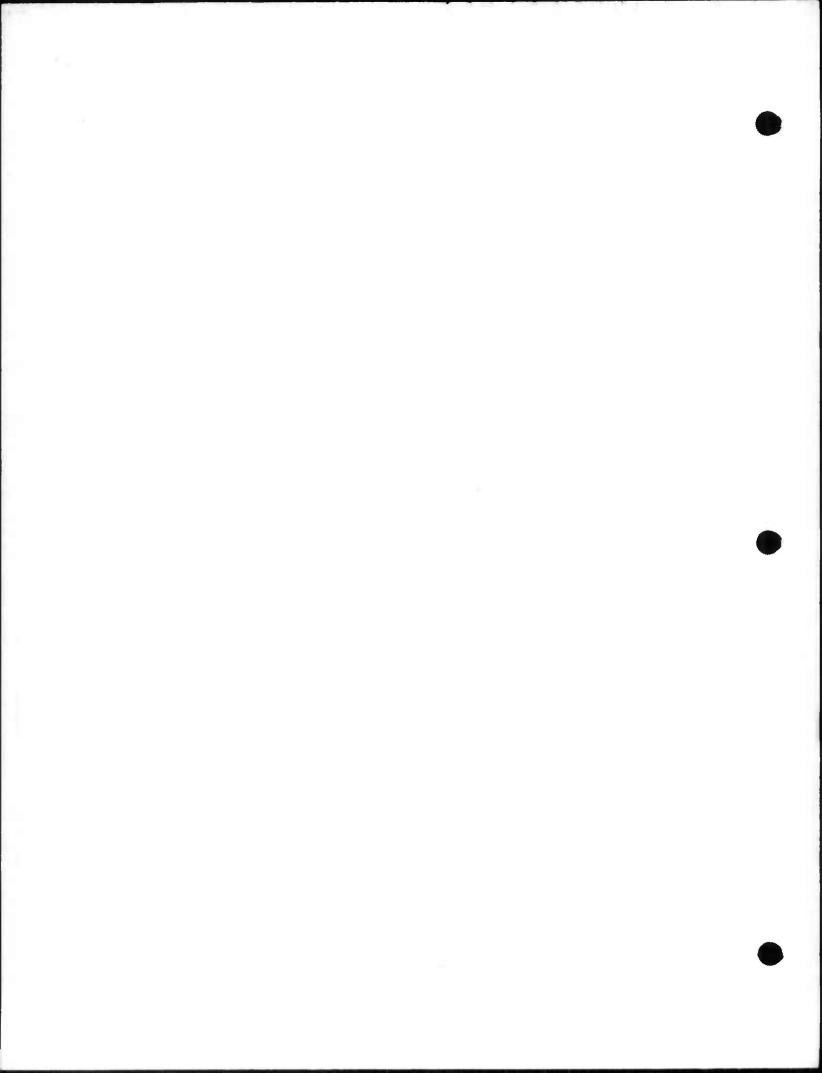
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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	FOR STATE REGISTRAR	STATE OF MARYLAND		RTMENT OF H		MEN	TAL HYGIEN REG. NO.	E		
	1. DECEDENT'S NAME (First, Middle, Last)						ATE OF DEATH	NY.	YEAR	3. TIME OF DEATN
- 11		tle, Jr.		Т		_	cember 1	.6 1	995	8:15 a ^m
	4. SOCIAL SECURITY NUMBER 711-07-4840	5. SEX 6. AGE (In yrs	last birthday)	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	(A	ATE OF BIRTH forth, Day, Year)	1010	Country)	LACE (State or Foreign
	9a. FACILITY NAME (If not institution, give si	,	Tho.	9b. CITY, TOWN (D I OCATION OF		ne 15,	_	Mar NTY OF DE	ryland
E	Lorien Nursing			Balti		DEATH		90.000	N/A	NIT.
5	RESIDENCE OF DECEDENT									
IRE	10e. STATE 10b. COUNTY		10c. Cl	TY, TOWN OR LOCAL						10d. INSIDE CITY LIMITS?
2	Maryland 100, STREET AND NUMBER	N/A		Baltimor	. ZIP CODE			10a CIT		IX YES 2 NO
FUNERAL DIRECTOR	5019 Pilgrim R	oad			21214					States
S	11. MARITAL STATUS	12. WAS DECEDENT EVER IN U.S.	ARMED		ENDENT OF HISE		RIGIN? (Specify Yes		14. RACE	- American Indian.
BY F	1 Never Married 2 Merried 3 Widowed 4 Divorced	FORCES? 1 X YES 2 IF YES, GIVE WAR OR DATES	□ NO		ecify Cuben, Mex 2 NO Spe		erto Rican, etc.)		Black, Specify	White, etc.
	15. DECEDENT'S EDUC	WW II		4	——————————————————————————————————————		The many 22 201	1000		White
1	(Specify only highest grade	completed)	(Give kind of ilfe. Do NOT	S USUAL OCCUPATION Work done during mouse retired.)	ist of working		16b. KIND OF BUS	SINESS/IN	DUSTRY	
PL	Elementary/Secondary (0-12)	College (1-4 or 5 +)	Elec	trician			Rail	road		
COMPLETED	17. FATHER'S NAME (First, Middle, Last)				18. MOTNER'S	NAME (F	irst, Middle, Meiden			
BE 0	Harry H Littl	e, Sr.			Ju	lia	E. Ford			
10	19e. INFORMANT'S NAME (Type/Print)			G ADDRESS (Street						
	Mr. Clarence H			1 Pilgri			altimore	-	7	
	20s. METNOD OF DISPOSITION 1 X Burlet 2 Cremetton 3 Rem 4 Donetton 6 Other (Specify)	oval from State 20b.PLA	CE AND DATE c, crematory or	of disposition (Na other place) Cemetery	arme of	2/10	DATE 20c. LO		City or Tow	
	21. SIGNATURE OF FUNERAL SERVICE LIC	CENSEE Mark T. Za	vovna	22. NAME A	on Address of Tard J.	FACILITY	(-	1 I C I II	iore,	Maryland
	> Mark T. Za	Dr.		Leoi			k, Inc. oad ba	altim	ore,	Md. 21214
	23. PART I. Enter the diseases, or enough or heart failure.	I let ente en enter en ente	Max a							Approximate Interval Between
	IMMEDIATE CAUSE (Finel disease or condition	DUE TO (OR AS A CO)	Δ	~ 0	~ /	16	and t	10.	000	Onset and Death
	resulting in daeth)	2011 3400	e d	and the same		-		-	ゾーン	neon
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Į į	Sequentially list conditions, if any, leading to immediate	DUE TO (OR AS A COM	NSEQUENCE	OF):			d' ses	J		The state of
CERTIFICATION	cause. Enter UNDERLYING CAUSE (Disease or Injury	с								
TE	that initiated events resulting in deeth) LAST	DUE TO (OR AS A CO	NSEOUENCE	OF):						
SEA	Tooling in dodiny case	d								+
	PART II. Other significent condition	na contributing to death but n	ot reaulting	In the underlyin	g ceuse given	In Part	I. 24s. WAS AN			WERE AUTOPSY FINDINGS
EDICAL							1 TYES 2	. /		COMPLETION OF CAUSE OF DEATN?
Σ										1 TES 2 NO
AN.	DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL			ES LI NO L	UNCERT	AIN L				
iC	EXAMINER?	HOSPITAL: 1 Inpetient 2 ER/Outpetier		OTHER:						
PHYSICIAN:	27. MANNER OF DEATH	28s. DATE OF INJURY	26b. Ti	4 Nursing Nor ME OF 28c. IN	JURY AT		Other (Specify) DESCRIBE NOW I	INJURY O	CCURED	
ву Р	1 Naturel 5 Pending investigation	(Month, Day, Year)	10	M 1 🗆	YES 2 NO					
ED B	3 Suicide 6 Could not be	26e. PLACE OF INJURY — A building, etc. (Specify)	At home, ferm	, street, factory, offic	:0	261.	LOCATION (Street City or Town, Stete)		w or Rural Ro	oute Number,
TE	4 Nomicide determined	,					ony or rown, oreie,			
PLE		ICIAN: To the best of my knowledge	e, death occu	rred at the time, date	end place, end	due to th	e cause(e) end ma	nner as st	nted.	
COMPLET	one) 2 MEDICAL EXAMINE	ER: On the basis of examination and	d/or investigat	tion, in my opinion,	death occured at	the time,	data and place, er	nd due to	the ceuse(e)	end manner ee stated.
BE (296. SIGNATURE AND TITLE OF CERTIFIE				29c. LICENSE I			29d. DA	TE SIGNED	Month, Day, Year)
10	an Marie AMP ADDRESS OF STREET	~ Goal.			008	35	X		121	16195
	30. NAME AND ADDRESS OF PERSON WN	COMPLETED CAUSE OF DEATH		oo. Print)						
	31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATUI		750			_			
	DEC1 91995	Tali Mudeer Rad	11							
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		1 - FOR STATE REGISTRAR	STATE OF MARYLA	ND / DEPAR	TMENT OF I	HEALTH AND	MENTAL HYGIEI			
		1. DECEDENT'S NAME (First, Middle, Last) LEVAUN	LUNSFORD				2 DATE OF DEATH	PD 19	3. TIME OF	DEATH P M
/		4. SOCIAL SECURITY NUMBER 217-20-7252	1 1 PM 2 TE	yrs. last birthday) YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) AUG. 15,		NORTH CA	
2, 3 should	OR	9a. FACILITY NAME (If not institution, give si 29 SOUTH CALVERT	treet and number)			OR LOCATION OF D			Y OF DEATH	
Pages 1,	DIRECTO	100. STATE 10b. COUNTY	/ I/A	10c, CITY	TOWN OR LOCA	TION LTIMORE			10d. INSIDI	8?
sit permit,		10e. STREET AND NUMBER				of. ZIP CODE	223	_	1X YES	
5-0020 nding physician. is the burlal-transit	Y FUNERAL	29 SOUTH CALVERT 11. MARITAL STATUS 1 X Never Metried 2 Married	12. WAS DECEDENT EVER IN U FORCES? 1 YES IF YES, GIVE WAR OR DATE	2 NO	If yes, sp	CENDENT OF HISPA	NIC ORIGIN? (Specify Year, Puerto Rican, etc.)		4. RACE — Americe Black, White, atc. Specify:	n Indien,
2 # 8	TED BY	3 Wildowed 4 Divorced 15. DECEDENT'S EDUC (Specify only highest grade	CATION	18e. DECEDENT'S	USUAL OCCUPATI	ON	16b. KIND OF BU		BLACK	
the hospital or detached for u	COMPLET	Elementary/Secondary (0-12) 6th GRADE 17. FATHER'S NAME (First, Middle, Last)	College (1-4 or 5 +)	We. Do NOT use	MPLOYED	Tallian and the	N/A			
1 2 2 E	BE	NORMAN 190. INFORMANT'S NAME (Type/Print)	LUNSFORD	T and MARIEN	ADDD500 (0)	MARZELL		-UNKNOW		
2 2 2	인	NANCY JACKSO		29 SOU	TH CALV	ERTON RO.	AD, BALTIM	MORE, M	IARYLAND	21223
mector,		1 XBuriel 2 Cremation 3 Remark 4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICE	cemete MT	ery, cremetory or oth	nar place) CEMETERY		-14-95 B		RE, MARY	LAND
SALIIN Safter death, Pag i by the funeral di removal. dical examiner	Ц	· Who	0-10	\bigcirc	JOSEF 1913	PH H. BRO W. BALTI	WN JR. FUR MORE ST.,	BALTIN	MORE, MD.	21223
ted within 24 hours after completely filled in by the ial, cremation, or remova event, the medical		23. PART I. Enier the diseases, or cahock, or heart fellure. I IMMEDIATE CAUSE (Final disease or condition resulting in death)	DUE TO (OR AS A C	sh line. Sclu	Air	Hand	th as cardiac or rass	piratory arrea	Inter	oximate val Between et and Death
be exacu	ERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury	DUE TO (OR AS A C							
ending Hygier	CERTIF	that initiated events resulting in death) LAST	DUE TO (OR AS A C	ONSEQUENCE OF): 					
of the d	EDICAL	PART II. Other alghificent condition:	s contributing to death but	no resulting is	the underlyin	ig ceuse given in		PRMED?	24b. WERE AUTO AMILABLE I COMPLETIO OF DEATH?	
has b Dept.	SICIAN: M	DID TOBACCO USE CONTR		DEATH YE		UNCERTAI	N 🗆		1 TYES	2 NO
Certificate the State	HYSIC	EXAMINER? 1 ☑ YES 2 ☐ NO 27. MANNER ØF DEATH	HOSPITAL: 1 Inpetient 2 ER/Outpeti		OTHER: 4 Nursing Hon	na 5 Residence	6 ☐ Other (Specify) 26d, DE\$CRIBE HOW	IN HIRW COOL	200	
	ВУ Р	1 Netural 5 Pending 2 Accident Investigation 3 Suicide 8 Could not be	(Month, Day, Year) 28e. PLACE OF INJURY —	- At home, ferm, at	M 1	YES 2 NO	281. LOCATION (Street			
OR ATTENDING DIRECTOR: After hours after death item 28 is ma	MPLETED	4 Homicide determined	building, etc. (Specify	")			City or Town, Stell	•)		
로 보고 된	COMP	one) 2 MEDICAL EXAMINE	CIAN: To the best of my knowled							r ee stated.
TO THE HOSPI TO THE FUNER be filed within	TO BE	30. NAME AND ADDRESS OF PERSON WHO	2\VN	-, W	D	29¢ LICENSE NUI	63	PAC	C 12, 14	195
		31 DATE FILED (Month Day Mar)	EURAN 32. REGISTRAR'S SIGNAT	10	140 0	W. BAL	TST 7	BALT	- MD 2	1223
		UEU1 91995	A Devision of							



5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hos	TO THE FUNEFAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detach	be fined written 72 hours are death with the state belt, or regula and mental hours to build, clemator, or entroad. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	
TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the dea	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the at	be filed within 12 hours after ceatif with the State Debt, or nearly and werkar hygenic print to build, uteriation, or entroval. IMPORTANT: If I item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical expending the medical expending the statement of the statement o	

	1 - FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REGISTRAR CERTIFICATE OF DEATH REG, NO.							
	1. DECEDENT'S NAME (First, Middle, Last) EIMET Lycille McMillan 2. DATE OF DEATH MONTH DAY MON	3. TIME OF DEATH 4:55 PM						
	4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. liest birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH Count OF BIRTH COUNTS DAYS HOURS MIN. (Act 1) 1 1 M 2 YF YRS. YRS.	IPLACE (State or Foreign						
TOR	98. FACILITY NAME (If not institution, give street and number) 99. CITY, TOWN OR LOCATION OF DEATH 90. COUNTY OF C Baltimore A PESIDENCE OF DECEDENT	EATH /A						
DIRECTOR	100. STATE 10b. COUNTY NA Baltmore	10d. INSIDE CITY LIMITS? 1 X YES 2 NO						
FUNERAL	100. STREET AND NUMBER Grantley Road 101. ZIP CODE 109. CITIZEN OF V	VHAT COUNTRY?						
B	11. MARITAL STATUS 1	E — American Indian, k, White, etc.						
COMPLETED	15. DECEDENT'S EQUCATION (Specify only highest grade completed) Elementary/Seconglary (0-12) College (1-4 or 5+) College (1-4 or 5+) College Wife Wife Wife Wife Wife Wife Wife Wif							
	17. FATHER'S NAME (First, Middle, Last) Tames Bruce Fauce He 18. MOTHER'S NAME (First, Middle, Malden Surname) A U.C. M. Tabscott							
TO BE	Bruce I. Mc 41/an 196. MAILINO ADDRESS (Street and Number or profile Noute Number, City or Your, State, Zip Code)	1:11c Hd						
	20s, METHOD OF DISPOSITION 1 Surial 2 Gremation 3 Removal from State 20s/PLACE AND DATE OF DISPOSITION (Name of the place) 20s/PLACE AND DATE OF DATE O	11/L Hd 21215						
	23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,	Salto, HU						
	IMMEDIATE CASE (Final	Interval Between Onset and Death						
z	disease or condition resulting in death) a. Due to (or as a consequence of): Unifierly tract infection	lwk						
CATIO	If any, leading to immediate cause. Enter UNDERLYING	lwk						
CERTIFICATION	CAUSE (Disease or Injury that Initiated eventa resulting in death) LAST							
MEDICAL CE	PART II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. Multiple decubitus vicers, multi-infarct dementia 1 yes 2 no 24a. WAS AN AUTOPSY PINDINGS AMALABLE PRIOR TO COMPLETION OF CAUSE DF DEATH? 1 YES 2 NO							
AN:	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES IN NO IN UNCERTAIN							
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1							
ву РН	27. MANNER OF DEATH 1 Netural 5 Pending Investigation 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY WORK? 1 YES 2 NO							
	2 Accident investigation 3 Suicide 6 Could not be detarmined 28e. PLACE OF INJURY — At home, farm, etreet, factory, office building, etc. (Specify) 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
COMPLET	29e. CERTIFIER (Check only one) CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Description of the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	s) and manner ea stated.						
O BE CC	296 SIGNATURE AND TITLE OF CERTIFIER 296. LICENSE NUMBER 296. LICENSE NUMBER 296. LICENSE NUMBER 296. LICENSE NUMBER 296. LICENSE NUMBER 296. LICENSE NUMBER 296. LICENSE NUMBER 296. LICENSE NUMBER 296. LICENSE NUMBER 296. LICENSE NUMBER 296. LICENSE NUMBER 296. LICENSE NUMBER 296. LICENSE NUMBER 296. LICENSE NUMBER 296. LICENSE NUMBER 296. LICENSE NUMBER 296. LICENSE NUMBER 296. LICENSE NUMBER 296. LICENSE NUMBER 297. LICENSE NUMBER 296. LICENSE NUMBER 296. LICENSE NUMBER 297. LICENSE NUMBER 296. LICENSE NUMBER 297. LICENSE NUMBER 296. LICENSE NUMBER 297. LICENSE NUMBER 296. LICENSE NUMBER 297. LICENSE NUMBER 296. LICENSE NUMBER 297. LICENSE NUMBER 297. LICENSE NUMBER 298. LICENSE NUMBER 297. LICENSE NUMBER 298. LICENSE							

ERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Typo, Print)

K MD Sirai Hospi tal 2401 W, Belvedere Ave, Britimore, MD 21215

32. REGISTRAR'S SIGNATURE

Jali David Completed Cause of Death (ITEM 27) (Typo, Print)

Jali David Completed Cause of Death (ITEM 27) (Typo, Print)

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Jali David Cause of Dea

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36. NAME AND ADDRESS OF PER Jennifect for 31. DATE FILED (MONIN, Day, Yold) UEU1 91995

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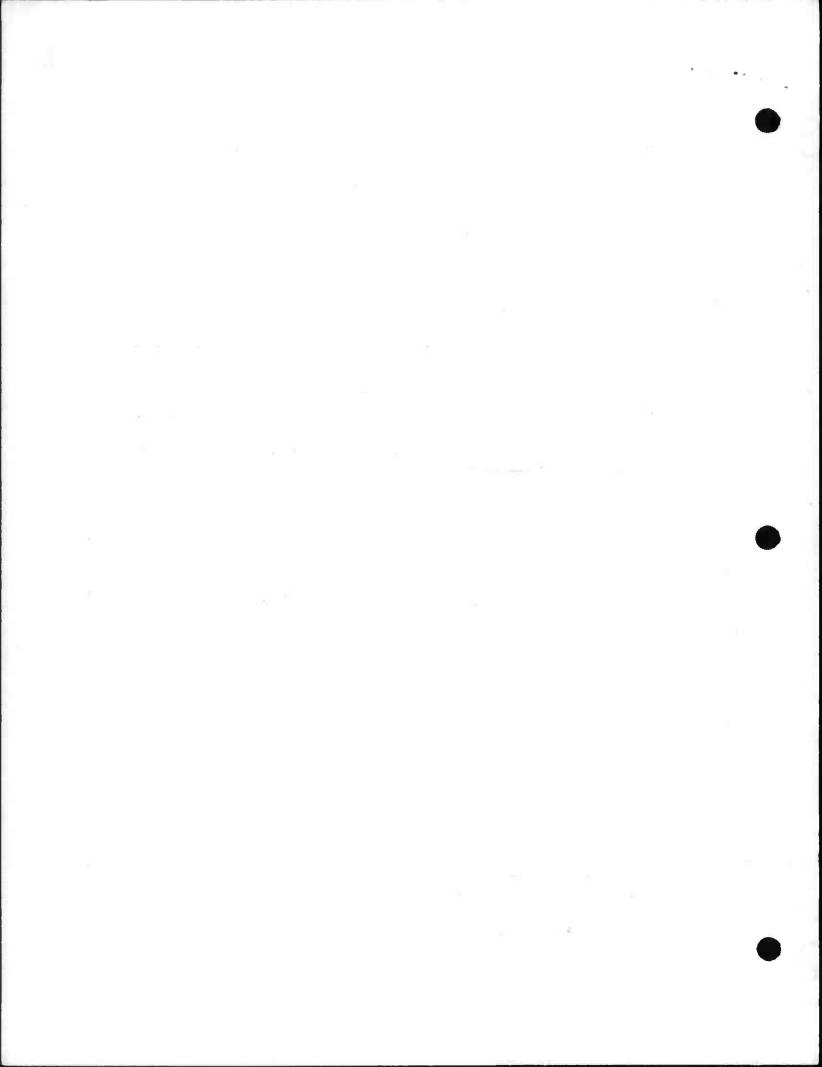
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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunal-transit permit. Pages 1. 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1	1 - FOR STATE REGISTRAR	STATE OF MARYLA	AND / DEPAR	TMENT OF H	IEALTH AND	MENTAL HYGIEN		00202	
	1. DECEDENT'S NAME (First, Middle, Last)	1				2. DATE OF DEATH		3. TIME OF DEATH	
	acturation of the	ulinic DORIS	GERALDINE	MICULINIC		December !		1:20 A M	
	4. SOCIAL SECURITY NUMBER		n yrs. lest birthdey)	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)	8. BIR'	THPLACE (State or Foreign	
	237-24-6535		73 YRS.	MONTHS DAYS	HOURS WIN.	09-15-192	2 NORT	TH CAROLINA	
~	9a. FACILITY NAME (If not institution, give a NORTH ARUNDEL HOS			96. CITY, TOWN GLEN E	OR LOCATION OF DE	EATH	9c. COUNTY OF		
DIRECTOR	RESIDENCE OF DECEDENT	PIIAL		GUEN E	OURNIE		ANNE A	ARUNDEL	
EC	10e. STATE 10b. COUNTY	1	10c. CIT	Y, TOWN OR LOCAT	TION			10d. INSIDE CITY	
E	MARYLAND A	NNE ARUNDEL		CIEN	BURNIE			LIMITS?	
	10e. STREET AND NUMBER	MINE AMONDED			ZIP CODE		10g. CITIZEN OF	WHAT COUNTRY?	
ER	208 BERTRAM CIRCL	F.			21060		U.S.A	1	
FUNERAL	11. MARITAL STATUS	12. WAS DECEDENT EVER IN FORCES? 1 YES			ENDENT OF HISPAN	NIC ORIGIN? (Specify Yes		CE — American Indian, ick, White, etc.	
ВУБ	1 Never Married 2 Married 3 Widowed 4 Divorced	IF YES, GIVE WAR OR DA			2 PNO Specific	nn, Puerto Rican, atc.) y:		ioffy:	
	15. DECEDENT'S EDUC	CATION			Λ			WHITE	
E	(Specify only highest grade	completed)		WSUAL OCCUPATION Work done during mo		16b, KIND OF BUS	SINESS/INDUSTRY		
PL	Elementary/Secondary (0-12)	College (1-4 or 5+)	TEACHE			BOARD	F EDUCAT	TTON	
COMPLETED	17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NA	ME (First, Middle, Maiden		2011	
	ROY		COBURN		ROLAND	BLANCH		GRAY	
) BE	19. INFORMANT'S NAME (Type/Print)		19b, MAILING	ADDRESS (Street e	nd Number or Rural i	Route Number, City or Town	n, State, Zip Code)		
2	MILAN	MICULINIC	208	BERTRAM	CIRCLE.	GLEN BURN	IE. MD.	21060	
	20a. METHOD OF DISPOSITION 1X Burlel 2 Cremetion 3 Remi	20b.	PLACE AND DATE (OF DISPOSITION (No	ime of	DATE 20c, LO	CATION - City or	Town, State	
	4 Donation 5 Other (Specify)	GLI		MEMORIA		12/13/95 GLE	N BURNIE	E, MD.	
	21. SIGNATURE OF FUNERAL BERVICE LIC	INSEE		22. NAME A	ID ADDRESS OF FA	CLUTY SINGLET	ON FUNER	RAL HOME,	
	1			1 SECC	ND AVENU	E, S.W.,GL	EN BURN	[E,MD.21061	
	23. PART I. Enter the diseases, or o	complications that caused List only one cause on ea	the death. Do r	not enter the mo	da of dying, suc	h as cardiac or respi	ratory arrest,	Approximate	
	IMMEDIATE CAUSE (FIMI	Constitution of the cause of the	on line.		0-1			Interval Between Onset and Death	
	disease or condition resulting in death)	· Kasa	rad	m-	Janle	ue.		1 weak	
		DUE TO (OR AS	COMSEQUENCE OF	D)	N C	. \		0 0	
S	Sequentielly list conditions,	DUE TO (OR AN)	CONSEQUENCE OF	MEar	ur fa	~ mu		3 Weeks	
E	If any, leading to immediate cause. Enter UNDERLYING								
윤	CAUSE (Disease or injury that initiated events	DUE TO (OR AS A	CONSEQUENCE OF	n Cur	m	welva		· Jean	
CERTIFICATION	resulting in death) LAST	4				00		, ,	
	PART II Other elemitionst condition		4 4						
SA	PART II. Other algnificant condition	a contributing to deeth bu	it not reaulting	in the underlying	g ceuse given in	Part I. 24a. WKS AN PERFOR		b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO	
ă						1 TYES 2	DINO	OF DEATH?	
Σ	DID TORACCO LISE CONTR	DIBLITE TO CALISE OF	DEATH VE	C D NO E	LINICEDTAIN		1	1 TYES 2 NO	
PHYSICIAN: MEDIC	DID TOBACCO USE CONTI		8. PLACE OF DEAT		UNCERTAI				
SIC	EXAMINER?	HOSPITAL:		OTHER:	a & C Sanidana	6 Other (Specify)			
Η̈́	27. MANNER OF DEATH	28e. DATE OF INJURY	26b. TIM	E OF 28c. INJ	URY AT	28d. DESCRIBE HOW II	NJURY OCCURED		
ВУР	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Yeer)	INJ		RK7 /ES 2 NO				
	3 Suicide 6 Could not be	28e. PLACE OF INJURY building, etc. (Specific	At home, farm, a	street, factory, offic		281. LOCATION (Street e	and Number or Rural	Route Number,	
	4 Homicide determined		.,,			City or Town, Stelle)			
PLE	29a. CERTIFIER 1 DERTIFYING PHYSI	CIAN: To the best of my knowle	edge, death occurre	ed at the time, date	and place, and due	to the cause(e) end man	ner ee stated.		
COMPLETED		R: On the beele of examination						(a) and manner ea stated.	
	29b. SIGNATURE AND TITLE OF CERTIFIER	1111			29c LICENSE NUM	IBER	29d, DATE SIGNE	D (Month, Day, Your)	
3 BE	Jorge Perez-Alard				1)419	27	· 12/	18/95	
일	30. NAME AND ADDRESS OF PERSON WHO	O COMPUETED CAUSE OF DEA	TH (ITEM 27) (Type,	Print) 21061			-/-	10/1	
	3708 Mountain Roa			iu 21061					
	31. DATE FILED (MONTE) PY 1995	32 REGISTINATE SIGNA	Nordall						



111 Penn Street, Baltimore, Maryland 21201

State Registrar HEUDOREM, KING

DEC 1 9199

32. Registrar's Signature

abi Davidson Rordell

31. Data filed (Month, Day, Year)

DHMH 16 Rev 6/95

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31. DATE FILED (Month Day Year)

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32. REGISTRAR'S SIGNATURE

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nay be retained by the hospital or attending physician. page 5 should be detached for use as the bunal-tran Page 6 may be funeral director, hours after death. n by the f removal. completely filled in by 0 cremation. executed in and com to burial, the attending physician Mental Hygiene prior to DR ATTENDING PHYSICIAN: The law requires that the death certificate be and an pt. of Health an s certificate has be, in the State Dept. o. Item ?? this c DIRECTOR: After the hours after death villem 28 is mark TO THE HOSPITAL
TO THE FUNERAL I
be filed within 72 h
IMPORTANT: If II

95 38264 STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR 1 -CERTIFICATE OF DEATH 2. DATE OF DEATN 1. DECEDENT'S NAME Part. Middle Last. X30 A. MONTH 12 4. SOCIAL SECURITY MUMBER 2302 5, SEX 6. AGE (In vrs. last birthday) IF UNDER 1 YEAR | IF UNDER 24 HRS. 7. DATE OF BIRTH **M** 2 □ F JUN 10, 1942 53 MONTHS DAYS HOURS BALTIMORE, MD 216-42-2366 9a. FACILITY NAME (If not institution, give street SINAI HOSPITAL 9b. CITY, TOWN OR LOCATION OF DEATN 9c. COUNTY OF DEATN BALTIMORE CITY n/a DIRECTOR RESIDENCE OF DECEDENT 10a. STATE 10b. COUNT 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MARYLAND BALTIMORE n/a XX YES 2 NO 1908 E. 31st FUNERAL Street 10e. STREET AND NUMBER 101, ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 21218 UNITED STATES 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Year or No-14. RACE — American Indian, Black, Whits, alc. 1 Never Married 2XX Married FORCES? 1 YES 2 NO If yes, specify Cuben, Maxican, Puerto Rican, etc.)

1 YES 2XX NO Specify: Specify: BLACK BY 3 Widowed 4 Divorced COMPLETED 16a. DECEOENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5+) CEMENT CONSTRUCTION 12 FINISHER GRACE & SON th 17. FATNER'S NAME (First, Middle, Last) 18. MOTNER'S NAME (First, Middle, Maiden Sumame) ETHEL GAMBLE AMES MYERS BE 19a. INFORMANT'S NAME (Type/Print)
ROSA BELL 1908 nd Number of Paurel Poure Number, City of Town, State Zio Code |
ST STREET, BALTI MORE, MD 21218 2 MYERS 20e. METHOD OF DISPOSITION

1 A Burial 2 Cremation 3 Removal from State 20c. LOCATION - City or Town, State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE BALTIMORE PLACEMETERY 12 - 19BALTIMORE, MD 4 Donation 6 Other (Specify) . 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY WM. C. MARCH FH.-1101 E. NORTH AVENUE 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, Approximate shock, or heert fellure. List only one cause on each line. Interval Between Onset and Death IMMEDIATE CAUSE (Fine) disease or condition 6 WKS resulting in death) CERTIFICATION Sequentially list conditions, TO (OR AS A CO If any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF) that initiated events resulting in death) LAST PART II. Other significent conditions contributing to deeth but not resulting in the underlying cause given in Part I. MEDICAL 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS PERFORMED ato mega AVAILABLE PRIOR TO esseninted 10 VIRUS COMPLETION OF CAUSE OF DEATH? 1 TES 2 NO 1 XYES 2 - NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATN (Check only one) EXAMINER?

1 YES 2 NO

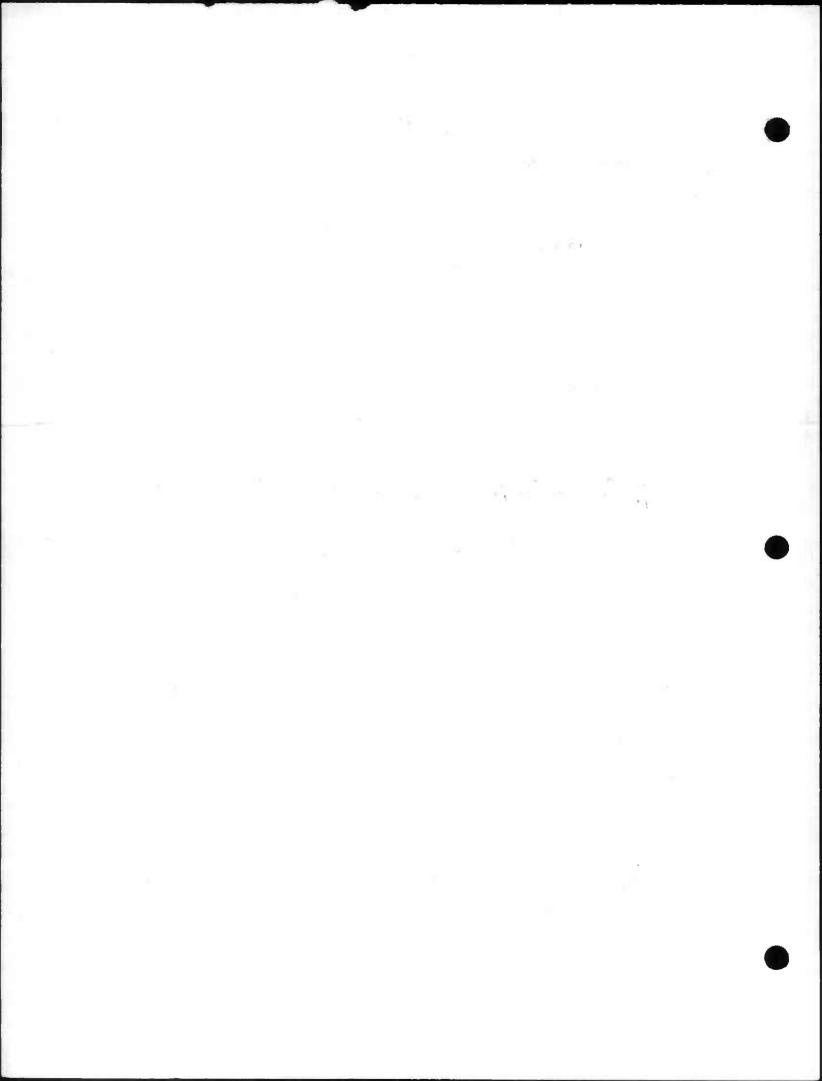
27. MANNER OF DEATN

1 Netural 5 [
2 Accident OTHER: Inpetient 2 ER/Outpetient 3 DOA 4 Nursing Nome 5 Rasidence 6 Other (Specify) 26e. DATE OF INJURY (Month, Day, Year) 26b. TIME OF 28c. INJURY AT 26d. DESCRIBE NOW INJURY OCCURED 5 Pending Investigation 1 YES 2 NO BY 28e. PLACE OF INJURY — At home, ferm, street, factory, office building, atc. (Specify) 261. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Suicide COMPLETED 6 Could not be 4 Nomicide CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(e) and manner as attated. (Check only one) investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated. Day, Year) BE 95 2 COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Paint)

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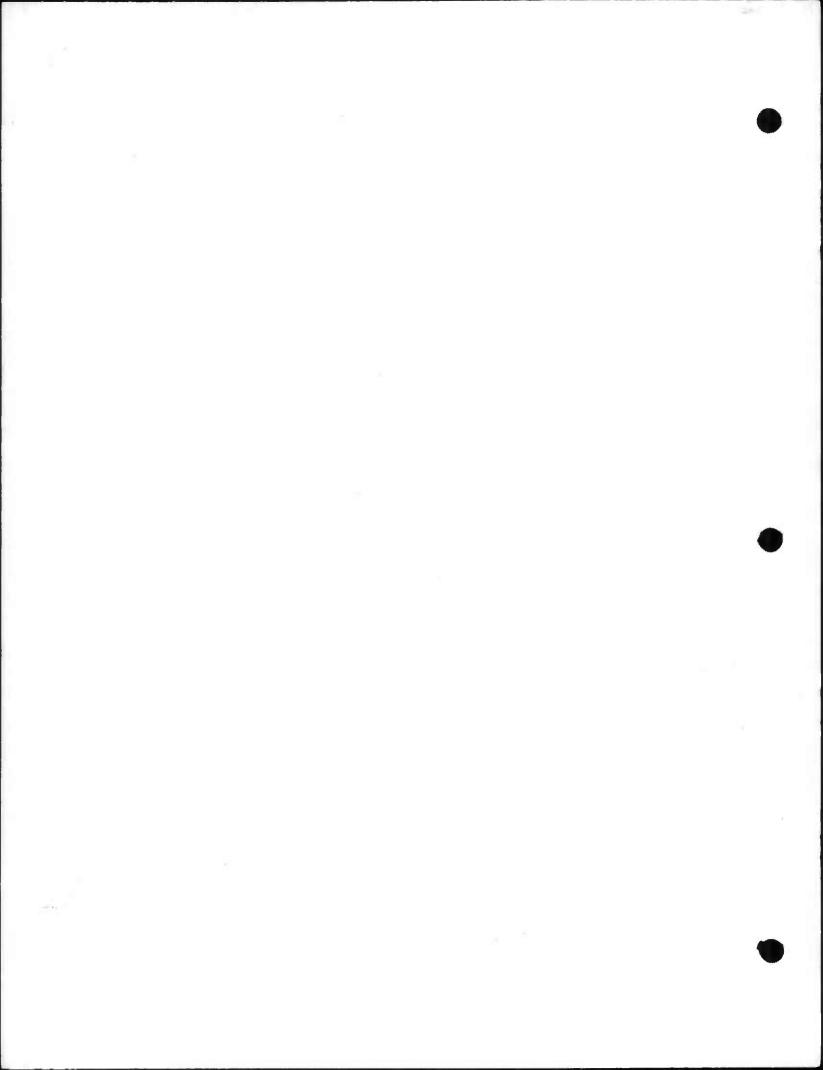


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BALLIM	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page (TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral direct be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT If item 28 is marked, or item 23 shows any injury or other traumatic event, the medical evanties or
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j	rtife	ng p	oth
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	PITA	RA L	200
	IOSI	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attanding physician and completely filled in by the for affect within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	AN
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	1	工作	APC
	H	2 2	=

31. DATE FILED (Month, Day, Year)
DEC1 91995

	1 - FOR STATE REGISTRAR	STATE OF !	MARYLAND A		RTMENT				MENT	TAL HYGIEN			00200
	1. DECEDENT'S NAME (First, Middle, Lest) JOSE	ph Augus							2. DA	ATE OF DEATH		1995	3. TIME OF DEATH 10:00 A
	4. SOCIAL SECURITY NUMBER 213-07-3698	5. SEX 1 M 2 F	6. AGE (In yra. Ia	st birthday) YRS.	IF UNDER 1	YEAR DAYS	IF UNDER	24 HRS. MIN.	Ju.	TE DF BIRTH	913	Count	HPLACE (State or Foreign
0 B	90. FACILITY NAME (II not institution, give st 110 N. Curley Stre				96. СІТУ, Т Balt			DN OF DE				UNTY OF I	
DIRECTOR	RESIDENCE OF DECEDENT 10s. STATE 10s. COUNTY Maryland N/A		-	10c. CIT	Y, TOWN OR			imor	re				10d. INSIDE CITY LIMITS? 1 YES 2 NO
FUNERAL	100. STREET AND NUMBER 110 N. Curley Stre	et				10f.	ZIP COD	L224				USA	WHAT COUNTRY?
B	11. MARITAL STATUS 1 Never Married 2 Merried 3 Widowed 4 Divorced	12. WAS DECEDEN FDRCES? 1 IF YES, GIVE V	YES 2 2	RMED NO	If y	yes, spe	olfy,Cuba	OF HISPAN n, Mexican Specify	n, Puer	GIN? (Specify Yea to Rican, atc.)	or No—	Blac	E — American Indian, ik, White, atc.
COMPLETED	15. DECEDENT'S EDUC (Specify only highest grade Elementary/Secondary (0-12)	CATION completed) College (1-4 or 5) (G	ive kind of Do NOT u	usual occ work done du se retired.) cenden	ring mos	N it of workin	ng		Race T		DUSTRY	
6 Jul	17. FATHER'S NAME (First, Middle, Last) George A. Ma	sel						M	lary	ot, Middle, Melden y Elizal	oeth		
2	Harry Weller Ruhl	198. INFORMANT'S NAME (TyperPrint) Harry Weller Ruhl, Jr. 198. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 630 Dunkirk Rd. Baltimore, MD 21212											
100	20b. PLACE AND DATE OF DISPOSITION DATE 20c. LOCATION - City or Town, State 20c. Signature of Date 20c. Location - City or Town, State 20c. Signature of Date 20c. Location - City or Town, State Date 20c. Location - City or Town, State Date												
248	George E. MacNa	Plos	E.M.	The	29	eman 9 Fi	rede	Soc. rick	iet Rd	y of Ma . Balti	ryla more	ind,	Inc. 21228
	23. PART i. Enter the diseases, or cahock, or heart failure. I. IMMEDIATE CAUSE (Final disease or condition resulting in death)	let only one cau	t caused the delege on each line	ı. P	(Who	na mod	la of dy	ng, auch	h aa c	ardiac or reapi	ratory a	rreat,	Approximata Interval Between Onset and Death US
RTIFICATION	Sequantially list conditiona, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in daath) LAST	DUE TO	(DR AS A CONSEI (DR AS A CONSEI (DR AS A CONSEI	DUENCE O	P: Uh-	= [u	ana f	Dir	~				
PHYSICIAN: MEDICAL CE	PART II. Other eignificant conditions	contributing to	death but not a	eauiting	in tha unda	arlying	causa	iven in I	Part i.	24a. WAS AN PERFOR	MED?	246	WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
CIAN:	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one)												
	EXAMINERY 1 YES 2 NO												
TED BY	2 Accident Investigation 3 Suicide 6 Could not be detarmined 4 Homicide 26a. PLACE OF INJURY — At home, farm, street, factory, office 26b. PLACE OF INJURY — At home, farm, street, factory, office 26c. PLACE OF INJURY — At home, farm, street, factory, office 26c. PLACE OF INJURY — At home, farm, street, factory, office 26c. PLACE OF INJURY — At home, farm, street, factory, office 26c. PLACE OF INJURY — At home, farm, street, factory, office 26c. PLACE OF INJURY — At home, farm, street, factory, office 26c. PLACE OF INJURY — At home, farm, street, factory, office 26c. PLACE OF INJURY — At home, farm, street, factory, office 26c. PLACE OF INJURY — At home, farm, street, factory, office 26c. PLACE OF INJURY — At home, farm, street, factory, office 26c. PLACE OF INJURY — At home, farm, street, factory, office 26c. PLACE OF INJURY — At home, farm, street, factory, office 26c. PLACE OF INJURY — At home, farm, street, factory, office 26c. PLACE OF INJURY — At home, farm, street, factory, office 26c. PLACE OF INJURY — At home, farm, street, factory, office 26c. PLACE OF INJURY — At home, farm, street, factory, office 26c. PLACE OF INJURY — At home, farm, street, factory, office 26c. PLACE OF INJURY — At home, farm, street, factory, office 26c. PLACE OF INJURY — At home, farm, street, factory, office 26c. PLACE OF INJURY — At home, farm, street, factory, office 26c. PLACE OF INJURY — At home, farm, street, factory, office 26c. PLACE OF INJURY — At home, farm, street, factory, office 26c. PLACE OF INJURY — At home, farm, street, factory, office 26c. PLACE OF INJURY — At home, farm, street, factory, office 26c. PLACE OF INJURY — At home, farm, street, factory, office 26c. PLACE OF INJURY — At home, farm, street, factory, office 26c. PLACE OF INJURY — At home, farm, street, factory, office 26c. PLACE OF INJURY — At home, farm, street, factory, office 26c. PLACE OF INJURY — At home, farm, street, factory, office 26c. PLACE OF INJUR								Route Number,				
COMPLETED	29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINER												i) and manner as stated.
TO BE CO	29b. SIGNATURE AND TITLE ON CENTIFIER	~~					29c. LICE	NSE NUM	BER /		29d. DAT	E SIGNED	(Month, Day, Year) 9, 1995
-	30. NAME AND ADDRESS OF PERSON WHO Simon V. Scalia, M		•				Balt	imor	e.	MD_2122	24_		

DHMH-18 Rev 1/89



BALTIMORE, MARYLAND 21215-0020

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TO THE HOSPITAL DR AT
TO THE FUNERAL DIRECT
DE filed within 72 hours a
IMPORTANT; If Item 2

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31. DATE FILED (Month, Day, Year)

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

32. REGISTRAR'S SIGNATURE

the Davidson Reveall

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH YEAR Allie Maki 995 10:30 a M November 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR | IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign DAYS HOURS 148 - 10 - 18781 M 2 X F 81 YRS. May 15, Minnesota 9a. FACILITY NAME (If not institution, give street and number) Sh CITY TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR 117 East Cecil Avenue North East Cecil 10c. CITY, TOWN OR LOCATION 10a STATE 10h COUNTY 10d. INSIDE CITY Maruland Cecil North East 1 YES 2 NO 10s. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? 21901 U.S.A. 117 East Cecil Avenue 11 MADITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or NoIf yes, specify Cuben, Maxican, Puerlo Rican, etc.) 14. RACE — American Indian, Black, White, etc. Specify: White If yes, specify Cuben, Maxican, Pu 1 YES 2 X NO Specify: 1 Never Married 2 Married BY 3 Widowed 4 Divorced 16a, DECEDENT'S USUAL OCCUPATION COMPLETED 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade comp (Give kind of work done during mo Elementary/Secondary (0-12) College (1-4 or 5 +) Medical Nurse 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Surname) Jake Puro Elvira Puro BE 19a, INFORMANT'S NAME (Type/Print) (son) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 811 Oakton Avenue-Romeoville, Illinois 60446 Wayne Ernest Maki 20e. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State 1 Buriel 2 Cremetion 3 Re
4½ Donation 5 Other (Specify) 21. SIGNATURE OF PUNERAL SERVICE LICENSES D. SC.Dh B. VanSant 22. NAME AND ADDRESS OF FACILITY State Anatomy Board-655 W. Baltimore Street Rm. B026-Baltimore, Maryland 21201-1559 23. PART I There the diseases, or complications that caused the deeth. Do not enter tha mode of dying, such as cardiac or respiratory arrest, shock, or heart feliure. List only one cause on each line. Approximata intervai Between **IMMEDIATE CAUSE (Final** Onset and Death ate Myo cardial Infarction
DUE TO (OR AS AICONSEQUENCE OF): disease or condition Acute resulting in deeth) LAD CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leeding to immediate cause. Enter UNDERLYING COPP CAUSE (Disease or injury DUE TO (QR AS A CONSEQUENCE QF): that initiated events HTN reaulting in death) LAST PART II. Other significent conditions contributing to deeth but not resulting in the underlying cause given in Part i. 24a. WAS AN AUTOPSY PERFORMED? MEDICAL 24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE 1 YES 2 NO 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \square NO \square UNCERTAIN \square PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE QF DEATH (Check only one) HOSPITAL: OTHER: 1 YES 2 NO 1 | Inpatient 2 | ER/Outpatient 3 | DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. MANNER OF DEATH 26s. DATE OF INJURY 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 Netural 5 Pending 1 YES 2 NO BY 2 Accident 26s. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 261. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Sulcide 6 Could not be determined COMPLETED 4 Homicide 29a, CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated. 2 MEDICAL EXAMINER: On the be ale of axamination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and menner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE aal

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours aher death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	1 - STATE REGISTRAR	STATE OF MARY			OF HEALTH		MENTAI	L HYGIENE		ad .	
	1. DECEDENT'S NAME (First, Middle, Last, BENJAMIN FRANK	CLIN MAY					2. DATE MONTE DEC	of OEATH DAY	Ĺ5, 1	YEAR 995	3. TIME OF DEATH 3:30 A. M
	4. SOCIAL SECURITY NUMBER 212-10-3159	5. SEX 6. AGE	(In yrs. last birthday) YRS.	IF UNDER 1	YEAR IF UNDE	R 24 HRS. MIN.	7. DATE (Month NOV	OF BIRTH 1, Day, Year) 27,191	L7	Countr	PLACE (State or Foreign
~	9a. FACILITY NAME (If not institution, give				TOWN OR LOCAT				9c. COUNT	TY OF D	EATH
5	31 Wendslow Ro	bad		Lu	thervil	le			Ba	ltir	nore
DIRECTOR	10a. STATE 10b. COUN Maryland Bal	timore		,	therville						10d. INSIDE CITY LIMITS? 1 YES 2 XNO
	10e. STREET AND NUMBER				10f. ZIP COD	DE 3C		T	10g. CITIZ	EN OF V	WHAT COUNTRY?
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BY FU	11. MARITAL STATUS 1 Never Married 2 Married 3 Divorced	12. WAS DECEDENT EVER FORCES? 1 YES IF YES, GIVE WAR OR 1	2 XNO	11.1	AS DECENDENT yes, specify Cub	an, Maxica	in, Puerto I		or No 1	14. RACE Black Speci	- American Indian, White, alc. White
COMPLETED	15. OECEDENT'S ED (Specify only highest grac Elementary/Secondary (0-12)	UCATION de completed) College (1-4 or 5+)	16a, DECEDENT': (Give kind of life, Do NOT	work done du	CUPATION ring most of work	ling	16b	KIND OF BUSI	NESS/INDU	STRY	
MPL	12 yrs.		Machi	ne Ope	erator			Western		ctri	lc
BE CO	17. FATHER'S NAME (First, Middle, Last) ROY P.			K	athe	rine	Middle, Maiden S Unkn	own			
2	19a. INFORMANT'S NAME (Type/Print) Frances B. May		the second secon		Street and Number OW Road						21093
	20s. METHOD OF DISPOSITION 1 Burlal 2 Decremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of Company Country C								A CONTRACTOR OF THE PARTY OF TH		
	21 SUBMETING OF FOREST STREET,								LO50 York Rd		
	· Calx	/ans/							•		Towson, Md.
	23. PART I. Enter the disease, or shock, or heart failure IMMEDIATE CAUSE (Final disease or condition resulting in death)	List only on cause on COPD	eech ilne.		he mode of d	ying, suc	h ss cerd	diac or reapin	atory arre	eat,	Approximate Interval Between Onset and Death + 10 yrs.
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): d.										
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Z Z	DID TOBACCO USE CON	TRIBUTE TO CAUSE				CERTAI	N 🗆				
200	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2X NO	L 28. PLACE OF DEATH (Check only one) HOSPITAL: 1 Inpatiant 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Master 8 Other (Specify)									
HA	27. MANNER OF DEATH	28a. DATE OF INJURY	28b. TI		Rec. INJURY AT WORK?	rampenca	-	SCRIBE HOW IN	JURY OCC	URED	
BY	1 Natural 5 Pending (Month, Day, Year) 2 Accident Investigation			М	1 YES 2	□ NO					
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2	30. NAME AND ADDRESS OF PERSON W Edward P. Cost		DEATH (ITEM 27) (Type 10 Gerar	_	. т	imon	ium,	Maryla	ind 2	1093	3
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FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH YEAR Dec. 13, 1995 10:55p Eugene Emory Martin 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign IF UNDER 1 YEAR IF UNDER 24 HRS. April 20,1929 Maryland 217-22-2707 17 M 2 - F 66 YRS 9a. FACILITY NAME (If not institution, give street and number, 9c. COUNTY OF DEATH 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore DIRECTOR 509 Dorsey Ave. Essex RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c CITY TOWN OR LOCATION 10d. INSIDE CITY Baltimore Essex Md. 1 YES 2 TINO FUNERAL 10a, STREET AND NUMBER 101 ZIR CODE 10g, CITIZEN OF WHAT COUNTRY? 509 Dorsey Ave. 21221 USA 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 100 IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 14. RACE — American Indian, Black, White, atc. 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-If yes, specify Cuban, Maxican, Puerlo Rican, etc.) 1 Never Merried 2 Merried 1 YES 2 NO Specify Specify. BY 3X Widowed 4 Divorced White 16a. DECEDENT'S USUAL OCCUPATION COMPLETED 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify (Give kind of work done life, Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) Langenfelder Local 37 7th OperatingEngineer once. 17, FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surneme) te Josephine Bernice Taylor Emory Lewis Martin BE notified 19a, INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 510 Dorsey Ave. Baltimore Md. 21221 John Martin Sr. e 20e. METHOD OF DISPOSITION
1 N Burial 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State must 4 Donetion 5 Other (Specify) Park Cemetery12/16/95 Baltimore MD. Loudon examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Connelly Funeral Home of Essex npletely filled in by the cremation, or removal. 300 Mace Ave. Baltimore Md medical 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or reapiratory arrest, shock, or heert failure. List only one cause on-each line. Approximsta Interval Between ŏ **Onset and Death** IMMEDIATE CAUSE (Final the ESPIRATORY FAILURE

DUE TO (OR AS A CONSEQUENCE OF): disease or condition resulting in death) event, TRUCTIVE LUNG DISERSE an and com to burial, FRONIC OBS traumatic CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if sny, leeding to immediate cause. Enter UNDERLYING the attending physician a Mental Hygiene prior to CAUSE (Disesse or Injury other DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 0 injury, PART II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 24b. WERE AUTOPSY FINDINGS 24s. WAS AN AUTOPSY MEDICAL certificate has been signed by the State Dept. of Health and PERFORMED? AMILABLE PRIOR TO any COMPLETION OF CAUSE 1 YES 2 ND shows a 1 - YES 2 - 40 DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: 23 28. PLACE OF BRATH (Check only one) 25. WAS CASE REFERRED TO MEDICAL EXAMINER? Hem Inpatient 2 Proutpatient 3 OTHER: 1 TES 2 KNO 4 Nursing Home 5 Realdence 8 Other (Specify) 10 27. MANNER OF DEATH 28a. DATE OF INJURY 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED with t marked, 1 Natural A 5 Pending Investigation 1 YES 2 NO BY DIRECTOR: After the hours after death v 2 Accident 28a. PLACE OF INJURY 28t. LOCATION (Street and Number or Rural Route Number, 3 Sulcida street, tactory, office 69 COMPLETED 6 Could not be 500 4 Homicide item 29a. CERTIFIER

CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(e) and manner se stated. TO THE HOSPITAL OF THE FUNERAL DE FILE WITHIN 72 HORIZANT: IF IN (Check only one) 2 MEDICAL EXAMINER: On the beels of axamination and/or investigation, in my opinion, death occurred at the time, data and place, 29b. SIGNATURE AND THE OF CERTIFIER 29c. LICENSE NUMBER BE

PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print, KCIGMAN, Me)

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TO THE HOSPITAL DR ATTENDING PHYSICIAN: The I	TO THE FUNERAL DIRECTOR: After this certificate ha	be filed within 72 hours after death with the State Di	IMPORTANT: If item 28 is marked, or item 2

TO SOUTH MANDER OF DISCOURTY BOUNDARY BOOK STATE OF SOUTH AND SOUT	FUNCER 24 MBS. 2. DATE OF DEATH DAY PEAR 2. TIME OF DEATH MONTH DAY PEAR 12:32 PM FUNCER 24 MBS. 17. DATE OF BRITH PAGE (Siets or Foreign Country) FUNCER 24 MBS. 17. DATE OF BRITH PAGE (Siets or Foreign Country) FUNCER 24 MBS. 18. BIRTHPLAGE (Siets or Foreign Country) FUNCER 24 MBS. 19. DATE OF BRITH PAGE (Siets or Foreign Country) FUNCER 24 MBS. 19. DATE OF BRITH PAGE (Siets or Foreign Country) FUNCER 24 MBS. 19. DATE OF BRITH PAGE (Siets or Foreign Country) FUNCER 24 MBS. 19. DATE OF BRITH PAGE (Siets or Foreign Country) FUNCER 24 MBS. 19. DATE OF BRITH PAGE (Siets or Foreign Country) FUNCER 24 MBS. 19. DATE OF BRITH PAGE (Siets or Foreign Country) FUNCER 24 MBS. 19. DATE OF BRITH PAGE (Siets or Foreign Country) FUNCER 24 MBS. 19. DATE OF BRITH PAGE (Siets or Foreign Country) FUNCER 24 MBS. 19. DATE OF BRITH PAGE (Siets or Foreign Country) FUNCER 24 MBS. 19. DATE OF BRITH PAGE (Siets or Foreign Country) FUNCER 24 MBS. 19. DATE OF BRITH PAGE (Siets or Foreign Country) FUNCER 24 MBS. 19. DATE OF BRITH PAGE (Siets or Foreign Country) FUNCER 24 MBS. 19. DATE OF BRITH PAGE (Siets or Foreign Country) FUNCER 24 MBS. 19. DATE OF BRITH PAGE (Siets or Foreign Country) FUNCER 24 MBS. 19. DATE OF BRITH PAGE (Siets or Foreign Country) FUNCER 24 MBS. 19. DATE OF BRITH PAGE (Siets or Foreign Country) FUNCER 24 MBS. 19. DATE OF BRITH PAGE (Siets or Foreign Country) FUNCER 24 MBS. 19. DATE OF BRITH PAGE (Siets or Foreign Country) FUNCER 24 MBS. 19. DATE OF BRITH PAGE (Siets or Foreign Country) FUNCER 24 MBS. 19. DATE OF BRITH PAGE (Siets or Foreign Country) FUNCER 24 MBS. 19. DATE OF BRITH PAGE (Siets or Foreign Country) FUNCER 24 MBS. 19. DATE OF BRITH PAGE (Siets or Foreign Country) FUNCER 24 MBS. 19. DATE OF BRITH PAGE (Siets or Foreign Country) FUNCER 24 MBS. 19. DATE OF BRITH PAGE (Siets or Foreign Country) FUNCER 24 MBS. 19. DATE OF BRITH PAGE (Siets or Foreign Country) FUNCER 24 MBS. 19. DATE OF BRITH PAGE (Siets or Foreign Country) FUNCER 24 MBS. 19. DATE OF BRITH PAGE (Siets or Foreign							9	5 382	269
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21. SIGNATURE OF FUNERAL SERVICE LICENSE 22. NAME AND ADDRESS OF PACILITY W. D.A. PROWAS K. Chopwack: E.H. A. 23. PART I. Enter the diseasea, or complications that found the death. Do not enter that mode of dying, such as cardiac or respiratory arrest, in the pack, or heart fellure. List only one cashe on each line. IMMEDIATE CAUSE (Fine) disease or condition resulting in death) DUE TO (or AS A CONSEQUENCE OF): B. Sequentially list conditions, full to graph of the sequence of the cause. Enter UNDERLYING CAUSE (Disease or Injury that Initiated events resulting in death) LAST DI CADE OF OR AS A CONSEQUENCE OF): B. Sequentially list conditions, full to graph of the underlying course given in Part I. DI CADE OF OR AS A CONSEQUENCE OF): C. CONSEQUE	ADDRESS OF FACILITY ROWSK! Chornack: F. H. P. A. Dandalk Ave. Balte., Hu. 21274 of dying, auch as cardiac or respiratory arrest, approximate Interval Batween Onset and Death Abscesses It days It days It days It yes 2 No UNCERTAIN 1 28d. Describe How injury occured 28d. Location (Specify) The days of Death? 1 yes 2 No 28d. Location (Specify) 28d. Describe How injury occured 28d. Location (Street and Number or Rural Route Number, City or Town, Stefe) 28d. Location (Street and Number or Rural Route Number, City or Town, Stefe) 28d. Location (Street and Number or Rural Route Number, City or Town, Stefe) 28d. Location (Street and Number or Rural Route Number, City or Town, Stefe) 28d. Location (Street and due to the cause(e) and manner as stated, with occurred at the time, date and place, and due to the cause(e) and manner as stated.		1 Buriel 2 Cremetion 3 Remova		PLACE AND DATE OF DIS	POSITION (Name of	DATE	20c. LOCATION —	City or Town, State	
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			29b. SIGNATURE AND TITLE OF CERTIFIED	1		29c. LICENSE N	UMBER	29d, DA	TE SIGNED (Month, I	Day, Year)
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)	1000 17100 1795	- 11	tolert los	Mmp						
		2	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF DE	ATH (ITEM 27) (Type, Print)					1 -
Robert Közel ZZ S. Greene St. Baltimore, MD Z	ne St. Baltimore, MD 21201				225.	Greene ;	5+, Bo	Itimore	MDZ	1201
II 31. UATE PILED (MONTH, Day, Year) I 32, REGISTRAR'S SIGNATURE			UEU1 91995	32. REGISTRAR'S SIGN	ATURE					

38270 Items23PartI,27,28a-f Item4 12-19-95 FilmG730 W.H. Per OCME&Fami95

BY FUNERAL DIRECTOR	DECEDENT'S NAME (First, Middle, Lest) RICHARD LOUIS MARTIN]	2. DATE OF OEATH			9 5 R	3. TIME OF DEATN 2:20 P		
	4. SOCIAL SECURITY NUMBER 225-68-1676	5. SEX 6. AG	E (In yrs. last birth	MONTHS		IF UNDER	24 HRS. MIN.	(Month	OF BIRTH Day, Year)	955	8. BIRTNPLACE (State or Foreign Country) Maryland			
	98. FACILITY NAME (If not Institution, give street and number) 6200 BLK.HILLEN ROAD BALTIMORE CITY 96. COUNTY OF DEATH 97. COUNTY OF DEATH										EATH			
		. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION										10d. INSIDE CITY LIMITS? 1 YES 2 NO		
	3613 Hickory Avenue				10f. ZIP CODE 2 1 2 1 1				10g. CITIZEN OF V			VHAT COUNTRY?		
	11. MARITAL STATUS 1 Never Married 2 Merried 3 Widowed 4 Divorced	R IN U.S. ARMEO S 2 XNO DATES	IMEO 13. WAS DECENDENT OF HISPAN											
PLETED	15. DECEDENT'S EDI (Specify only highest gradi Elementary/Secondary (0-12)		(Give kir. Ille, Do N						166. KIND OF BUSINESS/INOUSTRY					
TO BE COMPL	17. FATNER'S NAME (First, Middle, Last) 18. MOTNER'S							NAME (First, Middle, Meiden Surname) a Buchman						
	198. INFORMANT'S NAME (Type/Print) (Drothet & Sister 19b. MAILING ADDRESS (Street and Number or Pural Poute Number, City or Town, State, Zlp Code) Steven & Ida Martin													
	20a. METHOD OF DISPOSITION 1									wn, State				
7	ahock, or heart fallure. List only one cause on each line.										more Stree 201-1559 Approximata Interval Betwee Onset and Daet			
ERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	nny, leading to immediate use. Enter UNDERLYING USE (Disease or Injury It Initiated events DUE TO (OR AS A CONSEQUENCE OF):												
MEDICAL C	PART II. Other algnificant conditions contributing to death but not resulting in the underlying cause given						given in	Part I.	24a. WAS AN AUTOPSY PERFORMED?		246	24b. WERE AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO		
CIAN:	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) EXAMINER? OTHER:													
ETED BY PHYS	1 XYES 2 NO 27. MANNER OF OEATN 1 Natural 5 Pending 2 Accident investigation	1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Nome 5 Resident						28d. DESCRIBE NOW INJURY OCCURED Weather Subject exposed to very cold 28f. LOCATION (Street and Number or Rural Route Number)						
	4 Nomicide determined Found: in Woods City or Town, State) 6200 Blk Hillen Rd. Balto.													
COMPL	1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. Check only one 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(a) and menner as stated.													
TO BE	296. LICENSE NUMBER 296. LICENSE NUMBER 296. LICENSE NUMBER 296. LICENSE NUMBER 296. DATE SIGNED (Month, Day, Year) 30. NAME AND ADDRESS OF PERSON WHO COMPLETED AUSE OF DESTI (ITEM 27/type, Print)													
	MADDEGALL	FIRM	_		C+	root	. p	tal+	imoro	М-	1	and 21201		

A. REGISTRAR'S SIGNATURE

DEC1 9 1995

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. DIVISION OF VITAL RECORDS, P.O. BOX 68760

BALTIMORE, MARYLAND 21215-0020

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 95 3827

					Cei	rtificat	e of	Death	-	Reg. No.				
Physician	1. Decedant's Na	ame (First, Middla, La	ist)						2. Data of De Month	Day	Year	3. Time of Death		
The law requires that the death certificate be assecuted by Physician and by the site of t		bby Lou	Newcom						DEC.	-	995	2:30 A.N		
Examiner	4a. Fecility Neme	(If not institution, giv	re street and number,				4	lb. City, Town, or	Location of Deet	4c. County	of Death			
		Raincliffe						Sykesvil			arroll			
	5. Sociei Security 549 22 Usual Residence	9133	DM OFF	ge (In yrs. la 8	st birthday) Yrs.	If Undar Months	Deys	If Undar 24 Hrs Hours Min.	(Month, De	Dete of Birth (Month, Day, Year) arch 10, 1927 Birthplaca (Stata or Foreign Country) Texas				
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Page 1									10	Yes 2 No	10	Yas 25 No		
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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law TO THE FUNERAL DIRECTOR: After this certificate has be filed within 72 hours after death with the State Dept. IMPORTANT: If Item 28 Is marked, or Item 23 is	COMPLETE	(Check only		ER: On the best of											s) and manner as stated.
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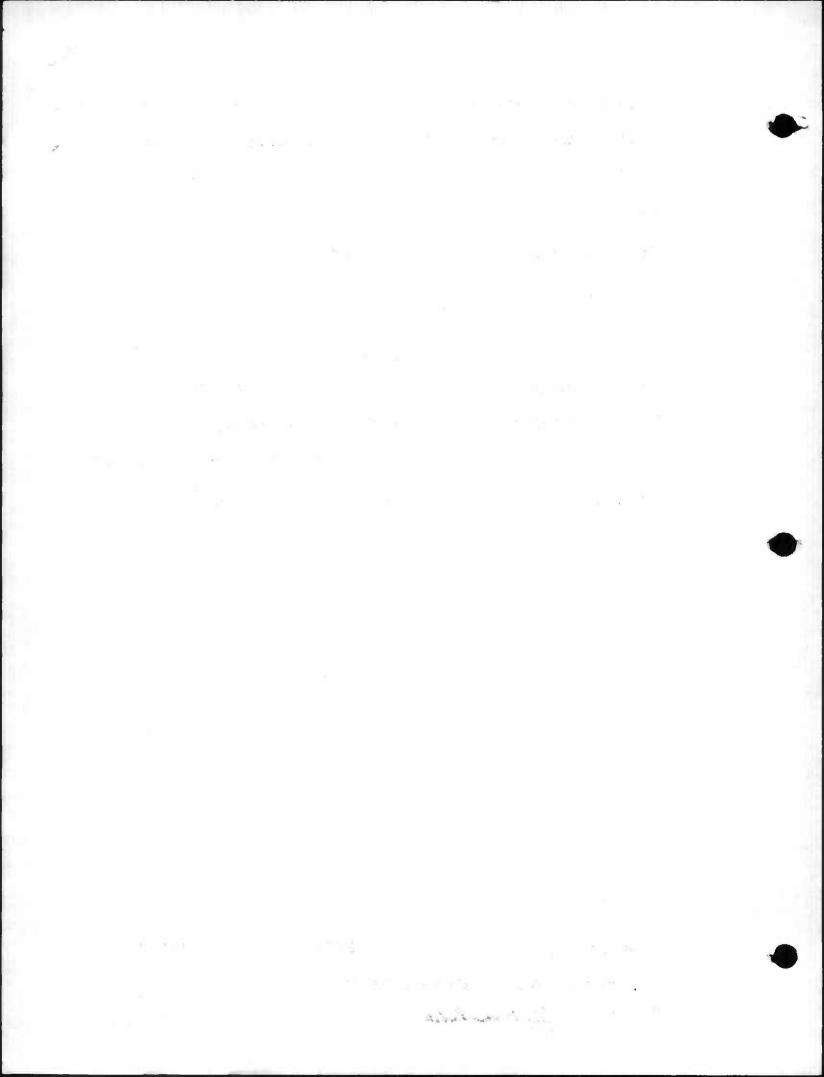
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene C

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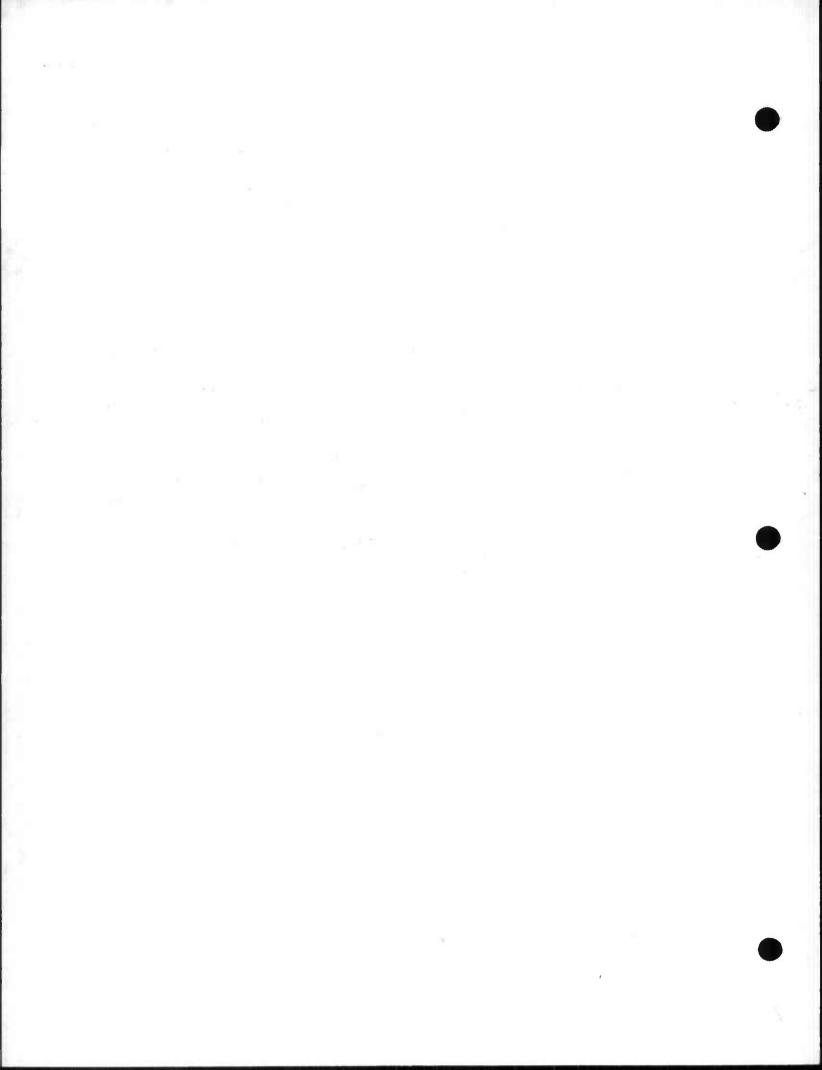
BALTIMORE, MARYLAND 21215-0020	hours after death. Page 6 may be retained by the hospital or attending physician.	s certificate has been signed by the attending physician and completely filled in by the funeral director page 5 should be detached for use as the burial-transit permit. Pages 1. 2, 3 should bit is State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	medical examiner must be notified at once.
DIVISION OF VITAL RECORDS, P.O. BOX 68760	TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed withman hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the f be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

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DIRECTOR	10a. STATE	10b. COUNTY			10c, CIT	Y, TOWN (OR LOCAT	ION						10d. INSIDE CITY
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FUNERAL	10e. STREET AND NUMBER						101	ZIP CODE				10g. CIT	ZEN OF	WHAT COUNTRY?
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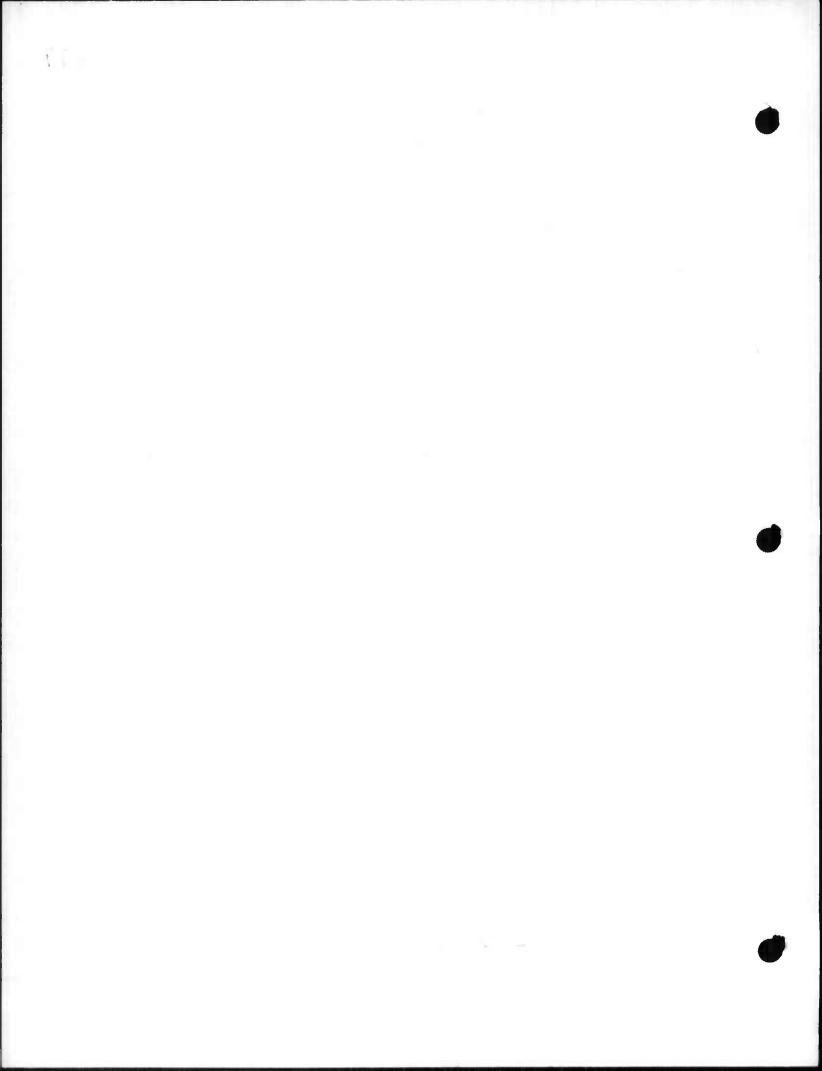
State of Maryland / Department of Health and Mental Hygiene

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Funerai		5. Social Security Number 6. Se	X 7. Age (in yrs. last birthdey) If Under Months	1 Yeer Deys	If Under 24 Hrs. Houre Min.	8. Dete of Birth (Month, Dey,	Year)	9. Birthpl Count	ece (Stete or	Foreign
Director		216-01-0538	95	Yrs.				Dec 21,				
and *		Usuel Residence of Decedent 10e, Stete 10b, County	1	Oc. City, Town or L	ocation						od. Inside City	Limits
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or 28	Oire	10e. Street end Number			10f. Zlp	Code		10	g. Citizen of \	Whet Count	try?	
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Z1Z13=-00Z0 d within 72 hours efter death with the Menyland jlene. r than "natural", or flems 23a or 28a-f show the Medical Examiner must be notified at	by Funeral Director	1 ☐ Never Married 2 ☐ Merried 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Detes:		1 ☐ Yes			o moan, etc.)	Specify			
2 ho	Be Completed	15. Decedent's Edu	cation	16a. Dec	edent's Usue	el Occup	petion	dula -	16b. Kind of B	usiness/ind	lustry	
within 7	ple	(Specify only highest great Elementery/Secondery (0-12)	College (1-4or 5+)	life.	DO NOT us	se retire	during most of word)	King				
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Adar 2 sho and is m	ľ	19e. Informent's Neme/Reletionship (T)	rpe, Print)	19b. Mei	ling Address	(Street	end Number or Ru	ral Route Number	City or Town,	Stete, Zip	Code)	
1 and 2 Health am 27 i		Col. William T.					e Apt 215	, Dunedi	n, Fla	3469	98	
of Harrist		20e. Method of Disposition 1 X Burial 2 Cremetion 3 □ F		20b. Plece of Disp cametery, cri	emetory or o	ther ple			Oc. Location	City or To	wn, Stete	
Pages nent of int: If Its		4 Donetlon 5 Other (Specify)	temover from Stete	Loudon	Park	Ceme	etery 1	2/18 B	altimo	re, Ma	aryland	£
Baltimore, Maryland 21215-002 permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If Itan 27 is marked other than "netural", any injury or other traumatic event, the Medical Exponse.		21. Signature of Funerel Service Licens	2 01/2) 1	22. Name en Burge	d Addre	enss Fune	ral Home	212	11		
		23a. Pert V. Enter the disease, or compl shock, or held feilure. List only o) Hens		3631	Fall	ls Road,	Baltimor	e, Mary	yland	Approximate	
Physician /Medicai Examiner	Aedical Examiner		D	Cleater	VAS	er and	en DIS	eene				
icete be executed physician and s the buriel-transit	Exar	Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury	Du	e to (or es e conse	equence of):					į		
68760, ificete be extended to physician as the buriel	cai	thet initieted events	c	e to (or es e conse	quenca of):							
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DOX ath cert ettendin for use	S		d							<u> </u>		
deat death e eth	Sicia	Pert II. Other significant conditions cor	ntributing to death but r	ot resulting in the	underlying c	ause civ	ven in Pert I.	23b. Did to	bacco use co	ntributs to	the cause of	death?
us, r.c. box ires that the death cer signed by the ettendin d be deteched for use	Physician/	Denertici			J			1 🗆 Yı	- \	3 Prob	He	Inknowr
De de la la la la la la la la la la la la la	Completed by							24a. Wes en	n autopsy ned?	sva	re eutopsy fin illable prior to npletion of car leath?	_
VICAL MEC sician: The lew certificate has b lirector, pege 2 s	E							1 □ Ye	s 22 No	1	Yes 2 N	10
	Bec	25. Wes case referred to medical					28. Plece of Dee	ath (Check only on	9)			
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g Phys er this neral di		27. Menner of Deeth	28e. Dete of Injury (Month, Dey Y	ear) 28b. Time	of 2	8c. Injui		28d. Describe ho				
Attending I or deeth. ector: After by the funer	atio	1 Neturel 5 Pending investigation	(Month, Day)	out/ injury	М		Yes 2 □ No					
LIVISION If or Attending after deeth. Director: After din by the fune	Certification:	3 Sulcide 6 Could not be determined	28e. Plece of Injury building, etc. (- At home, ferm, s Specify)	treet, fectory	y, office		28f. Location (St City or Town	reet and Numb , Stete)	ber or Rural	Route Numb	Θľ,
To the Hospital or Attending Physician: Within 24 hours after deeth. To the Funeral Director: After this certific completely filled in by the funeral director.	Medical C	29e. Certifier (Check only one) Certifying Physical Exami	sician: To the best of n nar: On the basis of ex end menner stete	eminetion end/or l	th occurred nvestigetion,	et the tir	me, date end plece	, end due to the ca rred at the time, de	use(s) and mo	enner as sto and due to	eted. the ceuse(s)	
ithin o the	Me	29b. Signeture end title of cartifier) A	••	290	. Licens	se number	2	d. Dete signe	d (Month. I	Day, Year)	
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Sta Regist		31. Dete fil	Julia di Managa	or working to			/					

BALTIMORE, MARYLAND 21215-0020

FOR STATE REGISTRAR	5	STATE OF MARY	LAND / DEPAR CERTIF	TMENT OF H	EALTH AND		HYGIENE REG. NO.			
1. DECEDENT'S NAME (First	I, Middle, Last)				JEANIN	2. DATE OF	DEATH		3. TIME OF C	DEATH
JAKE PLAK	OTARIS	(A.K.A.	PLAKOTO	RIS)		DECE	MRER 1	3. 199		5 Рм
4. SOCIAL SECURITY NUM	BER 5.		E (In yrs. lest birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF	BIRTH	6. Bi	RTHPLACE (State of	
552 28 45	70		75 YRS.	96, CITY, TOWN	OR LOCATION OF E	APRIL			EST VIRG	INIA
	ARD VA			FORT	HOWA				TIMORE	
FORT HOW RESIDENCE OF DE 10a. STATE MARYLAND	10b. COUNTY BALT	'IMORE	10c. CITY	TOWN OR LOCAL	ELEIGH				10d. INSIDE (LIMITS? 1 YES X	
					, ZIP CODE			10a, CITIZEN (F WHAT COUNTRY	44
2 702 THO	RNWOOD	COURT			2128	86			S.A.	
10s. STREET AND NUMBER 702 THO 11. MARITAL STATUS		WAS DECEDENT EVER		13. WAS DEC	ENDENT OF HISPA	ANIC ORIGIN?	Specify Year	or No.— 14. R	ACF — American I	Indian,
The state of the s		FORCES? XX YES	S 2 NO	If yes, sp	ecify Cuban, Maxic	can, Puarto Rici	en, etc.)	€	leck, White, etc.	
3 Widowed 4 Div	W W	ORLD WAR	R II		LAC				WHITE	
15. DEC	EDENT'S EDUCATION by highest grade comp	ON pleted)	18a. DECEDENT'S (Give kind of w	rork done durina ma	ON st of working	18b. Ki	ND OF BUSI	NESS/INDUSTR	Υ	
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¥		EARS	KESI	UKANTE				STAUR	ANT.	
		MODIC			16. MOTHER'S N			urname)		
EMMANUEL	PLAKO	TORIS				ZABETI		RIS		
O 198. INFORMANT'S NAME ((1		nd Number or Rura					
FOFT PLA		,			OOD COL	JRT, TO	1			1286
20a. METHOD OF DISPOSIT	on 3 - Removal	from Stata Co	b. PLACE AND DATE Of emetery, crematory or of	her place)		DATE		ATION — City o		
4 Donation 5 Other		IG	REEN MO	UNT CR	EMATORY	12-1	6 BA	LTO.	MD., 21	202_
^ .					D ADDRESS OF F	V. JEN	IKTNS	AND	SONS	
アで、次	But				YORK					212
23. PART I. Enter the c	Iseasea, or comp	olications that cause	ed tha death. Do n	ot anter the mo	de of dying, au	ch as cardiae	or respire	etory arrest,	Approx	Imate
IMMEDIATE CAUSE (FI		only one cause on	each line.							Batween
disease or condition resulting in death)	→	PARKINSO	N'S DISEAS	SE						EARS
readiting in death)			A CONSEQUENCE OF						7 11	CVIVO
z										
Sequentially list condition if any, leading to imme	iona,	DUE TO (OR AS	A CONSEQUENCE OF):						
CAUSE (Disease or Inju										
that initiated events	· .	DUE TO (OR AS	A CONSEQUENCE OF):						
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	int conditions co	entributing to death	but not resulting in	the underlying	t cause alvae le	- Port i	le. WAS AN A	manay I		
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DID TOBACCO U 25. WAS CASE REFERRED TO EXAMINER? 1 YES 2 XNO 27. MANNER OF DEATH	<u> </u>	EICCOILLI O.	o., DECOD.	LIOS OLK	ER	— I 1	XYES 2	NO	OF DEATH?	OF CAUSE
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DID TOBACCO U		JIE 10 CAUSE (UNCERTAI					
EXAMINER?	HC	SPITAL:	26, PLACE OF DEAT	OTHER:						
1 YES 2 XNO	1 (2	Inpetient 2 ER/Ou		4 - Nursing Hom	e 5 🗆 Residence	8 Other (S	pecify)			
1 Natural 5	Pending	(Month, Day, Year)			URY AT RK?	28d. DESCR	IBE HOW IN	URY OCCURED		
2 Accident	Investigation				ES 2 NO					
9 Distantation	Could not be	28e. PLACE OF INJUR building, etc. (Sp.	IY — At home, ferm, s ecify)	treet, factory, offic		281. LOCATIO	ON (Street and fown, State)	d Number or Rui	al Route Number,	
Tomiciae	datamined									
4 Homicide 29a. CERTIFIER (Check only one) 2 MED	IFYING PHYSICIAN	To the best of my kno	wiedge, daath occurre	d at the time, data	and place, and du	e to the ceuse(a) and menn	er as stated.		
One) 2 MED		the beals of examinati							e(e) end manner e	a stated.
	OF CERTIFIER		11 1		29c. LICENSE NU	IMBER		29d. DATE SIGN	ED (Month, Day, Ye	arl .
AIMAN	01	laur.	Mca.		D 111	950			MBER 13,	
30. NAME AND ADDRESS O		MPLETED CAUSE OF D	EATH (ITEM 27) (Type.	Print)	VIT	1 0 3			.шик 10,	1227
III					DO TENTAM)T) 3/AT	ST ABTO	01050		
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AURORA C. 31. DATE FILED (Month, Day, UEU 1 9 19	Year)	J2. REGISTRAR'S SIG		VLER, FU	RT HOWAR	CD, MAR	YLANL	21052		





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STATE REGISTRAR CERTIFICATE OF DEATH REG NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH YEAR John L. Parker 12 95 8:00 A 4. SOCIAL SECURITY NUMBER 5 SEY 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR 7. DATE OF BIRTH (Month, Day, Year) IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign DAYS 1. M 2 | F 263-07-3592 9-6-13 Maryland Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street end number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c, COUNTY OF DEATH DIRECTOR Broadmead 13801 York Road Cockeusville Baltimore RESIDENCE OF DECEDENT 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MARYLAND BALTIMORE COCKEYSVILLE 1 YES 2 NO permit. 10e, STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 13801 YORK RD. 21030 U.S.A. **bunial-transit** hospital or attending physician. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or NoIf yes, specify Cuban, Maxican, Puerto Rican, etc.)
1 YES 2 NO Specify: 14. RACE — American Indian, Black, White, atc. 1 Nover Married 2 Married IF YES, GIVE WAR OR DATES Specify. BY 3 Widowed 4 Divorced as the WHITE ETED 18e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY use (Specify only highest grade completed) for Elementary/Secondary (0-12) College (1-4 or 5+) COMPL detached INSURANCE REP. INSURANCE once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) 8 To LINDLEY E. PARKER ANNA TAYLOR BE director, page 5 should notified 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Plural Route Number, City or Town, State, Zip Code) 2 13801 YORK RD. APT. JOHN L. PARKER b-4 COCKEYSVILLE 21030. Pe 20b. PLACE OF DISPOSITION (Name of cemetery, cremetory or 20c. LOCATION - City or Town, State must GREEN MOUNT CREMATORY 12/95 BALTO., MD. examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY funeral HENRY W. JENKINS & SONS CO. William R. 4905 YORK RD. BALTO., MD. 942 medical 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximata filled in by shock, or haert failure. List only one cause on each line. interval Between 5 Onset and Death IMMEDIATE CAUSE (Final the disease or condition CARDIO PULMONARY ARREST Ridden completely reaulting in death) traumatic event, DUE TO (OR AS A CONSEQUENCE OF): the attending physician and com Mental Hygiene prior to burial, CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING DULLIPULEMIA
DUE TO (OR AS A CONSEQUENCE OF): CAUSE (Disease or injury other that initiated events resulting in death) LAST 10 23 shows any injury, PART ii. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part i. 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS MEDICAL AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? has been signed by Dept. of Health and PERFORMED? 1 YES 2 NO 1 YES 2 NO PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF OEATH (Check only one) item ; certificate the State HOSPITAL: OTHER: 1 TES 2 NO Inpatient 2 - ER/Outpatient 3 - DOA 4 Nursing Home 8 Residence 8 Other (Specify) 6 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT 28d. DESCRIBE HOW INJURY OCCUREO this c is marked, 1 Natural 5 Pending 1 YES 2 NO death BY 2 Accident After 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 28f. LOCATION (Street and Number or Rural Route Number, City or Tours State) 3 Suicide 8 Could not be DIRECTOR: / COMPLETED 4 Homicide 28 determined CERTIFIER (Check only one)

CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data end place, and due to the cause(a) and manner as stated. Item FUNERAL within 72 h MPORTANT: If 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and menner as stated. 296. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER BE HE HE 23 0 E AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

DHMH-18 Rev 1/89

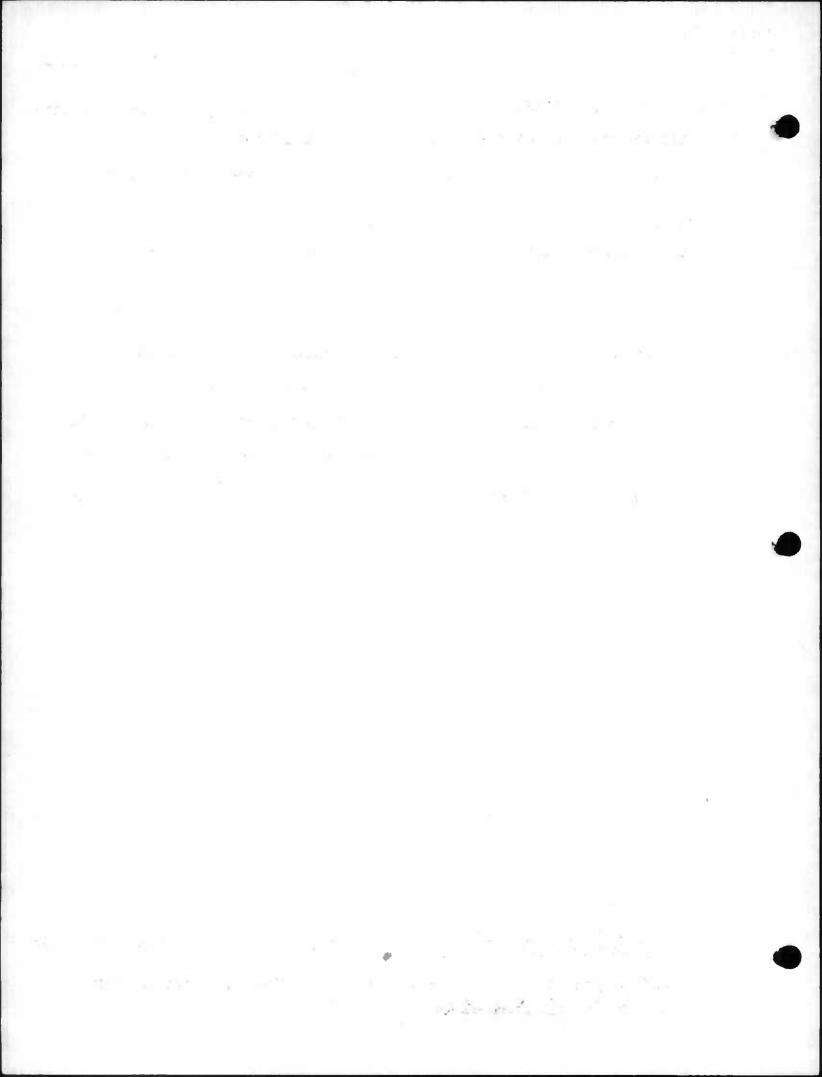
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State of Maryland / Department of Health and Mental Hygiene 95 38279

						Ce	rtificate	of	Death		Re	g. No.		
Phy	/siciar	,	1. Decedent's Nama (First, Middla, Las							2. Date Mon	of Death	Day	Year	3. Tima of Death
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Fund Direc			5. Sociel Security Number 6. Security Number 11 219-40-2398 Usual Rasidance of Decedant	7. Age	a (In yrs. le 52	est birthday) Yrs.	If Under 1 Months 1			Min. (Mor	of Birth hth, Dey,	Year) 1943	9. Birthp Coun MARYI	ece (Stata or Foreigr try) AND
yland	10		10a. Stata 10b. County		10c. City	, Town or Lo	ocation						10	Od. inside City Limits
Se-fa	Delinion ad		MARYLAND N/A	A		BA	LTIMORE							X Yas 2 No
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and ZIZIS-UUZU be filed within 72 hours after death with the Maryland ntal thygiene. dicther than "natural", or flema 23a or 28e-f ahow	EXAMPLE IN	Dy rui	11. Marital Stetus 1 Navar Married 2 Married 3 Widowed 4 Divorced	12. Wes Decedant E Armed Forces? 1 Yas 2 YN If Yas, Giva Yeer or Dates:			Was Deceder If Yes, specify 1 ☐ Yas 2 ☐	Cub	Hispanic Origin en, Mexicen, P Specify:	? (Specify Yas Puarto Rican, a	or No-		ce - Americ ck, Whita, o	etc.
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Maryland d 2 should be file th and Mental Hy 7 le marked othy		,	19a. Informant's Name/Ralationship (7) MARY PARKER (MOT	or Rural Routa										
Te, Heall		- 1	20a. Method of Disposition	nek/	20b. Ple	ece of Dispo	sition (Nama	of	STREET	Data		Oc. Location -		
mit. Pages 1 ar partment of Hea portant: If Nem 2 y injury or other	5		1 ☑ Burial 2 ☐ Cramation 3 ☐ I 4 ☐ Donation 5 ☐ Othar (Specify,		WOO	matary, crai DLAWN	CEMET	ERY	ce) []	12-18-9		BALTIM		
Dattimore, Marylar pemit. Pages 1 and 2 should be Department of Health and Menta Important: If them 27 is marked	SUC.	-	21. Signature of Funeral Service Licens	0. B		J1		Η.	BROWN					21223
		1913 W. BALTIMORE ST., BALTIMORE, MD. 23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such es cardiac or respiratory arrest, shock, or heart feilure. List only one ceuse on each line.												Approximate Interval Between
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the attent	Phyelclar		Pert It. Other significant conditions co	ntributing to death bu	ıt not resui	ting In tha u	ndarlying cau	sa giv	ven in Part I.	231	. Did tob	acco use co	ntribute to	the cause of death?
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this this	F		tv as 2 No 27. Megnar of Death	Hospital: 1 Inpatier 28e. Data of Injury		R/Outpatier 28b. Tima of				ng Home 5		nce 8 Oth)
ing Affe	ation		1 Natural 5 Pending Invastigation	(Month, Day	Year)	Injury	М 200	Mor 1	rk? Yas 2 □ No	200. Das	IGHD9 HOV	w anjury occur	180	
	Certification		3 Suicide 6 Could not be 4 Homicida detarmined	28a. Place of Injubuilding, atc.	ny - At hon . (Specify)	ne, farm, str	eet, factory, o	ffice		28f. Location (Street and Number or Rural Routa Number, City or Town, State)				
To the Hospital or within 24 hours of To the Funeral Documental Consolidate in the Funeral Document of the Funeral Document of the Funeral Document of the Funeral Document of the Indian Communication of the Indian Communicatio	edical		29e. Certifiar (Check only one) 1 Certifying Phy 2X Medical Examl	sician: To the best of nar: On the basis of end manner stet	axaminatio	ledge, death on and/or inv	occurred at the vastigation, in	ha tir my o	ma, deta and p opinion, deeth o	lace, and due occurred at tha	to the cau tima, dat	use(s) and ma te and plece,	annar as st and dua to	ated. tha cause(s)
To the Within To the	M		29b. Signatura and titla obcertifier	uk	^				e number			d. Date signe		
12		-	30. Nama and address of person who co	omplated cause of do	eth stem	23a) (Tune								
9]	THE DUKEM, K					t,	Balti	imore,	Ma	rylan	d 21:	201

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	1 - STATE REGISTRAR 1. DECEDENT'S NAME (First, Middle, Last	STATE OF MARY	CERTIF	ICATE OF	DEATH	REG. NO.		3. TIME OF DEATH
	JUDITH	,	ROSO	ŗ		DECEMBER .	¹ 4,199	5:00pm
	4. SOCIAL SECURITY NUMBER 157–10–6634	1 □ M 2 🗙 🕏	SE (In yrs. lest birthday)	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) APR. 22, 190	07	BIRTHPLACE (State or Foreig Country) PENNSYLVANIA
OR	99. FACILITY NAME (If not institution, give HEBREW HOME OF C		INGTON		OR LOCATION OF DE	EATH	9c. COUNTY	Y OF DEATH OMERY
DIRECTOR	100. STATE 10b. COUN	TY MONTGOMERY	10c, CIT	Y, TOWN OR LOCA'	TION			10d. (NSIDE CITY LIMITS? 1 X YES 2 NO
FUNERAL	100. STREET AND NUMBER 6121 MONTROSE RO				1. ZIP CODE 20852			N OF WHAT COUNTRY?
BY FUN	11. MARITAL STATUS 1 Never Merried 2 Merried 3 Widowed 4 Divorced	12. WAS DECEDENT EVE FORCES? 1 1 YE IF YES, GIVE WAR OF	ES 2 NO	If yes, sp	ENDENT OF HISPAN	NIC ORIGIN? (Specify Yearn, Puerto Ricari, etc.)	1.	I. RACE — American Indian, Black, White, etc. Specify: WHITE
ETED	15. DECEDENT'S ED (Specify only highest grad Elementary/Secondary (0-12)			USUAL OCCUPATION work done during more retired.)				
COMPL	17. FATHER'S NAME (First, Middle, Last)		BOOKKE	EEPER	18 MOTHER'S NA			Y GOVERNMENT
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TO B	MRS FLATNE R	WOLFSON			and Number or Rural I	E PESOTAL T	n, State, Zip Co VA 220	
	20a. METHOD OF DISPOSITION 1 N Burial 2 Cremation 3 Red 4 Donation 5 Other (Specify)	moval from State	BARON HI	KSCH'		12-17-1995		Y or Town, State CEN ISLAND,
	► allerou	e Leven	won	SOL :	REISTERS	& BROS., STOWN ROAD	BALTI	MORE, MD 21
	23. PART I. Enter the diseases, or	complications that cause						
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ERTIFICATION	IMMEDIATE CAUSE (Finel disease or condition resulting in death)	a. DUE TO (OR A:	n each line.	n: den	>	h as cardiac or respi	ratory arres	Approximate
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30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Typo, Print)

But I. Feldman, M.D., 6105 Montrose fd

31. DATE FILED (Marian Day, 1947)

12. REGISTRANIS SIGNATURE

June Day Marian Park 1947

12. REGISTRANIS SIGNATURE

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31. DATE FILED MONTH, Coy, Year)

32. BEGISTRAR'S SIGNATURE Julia Dave

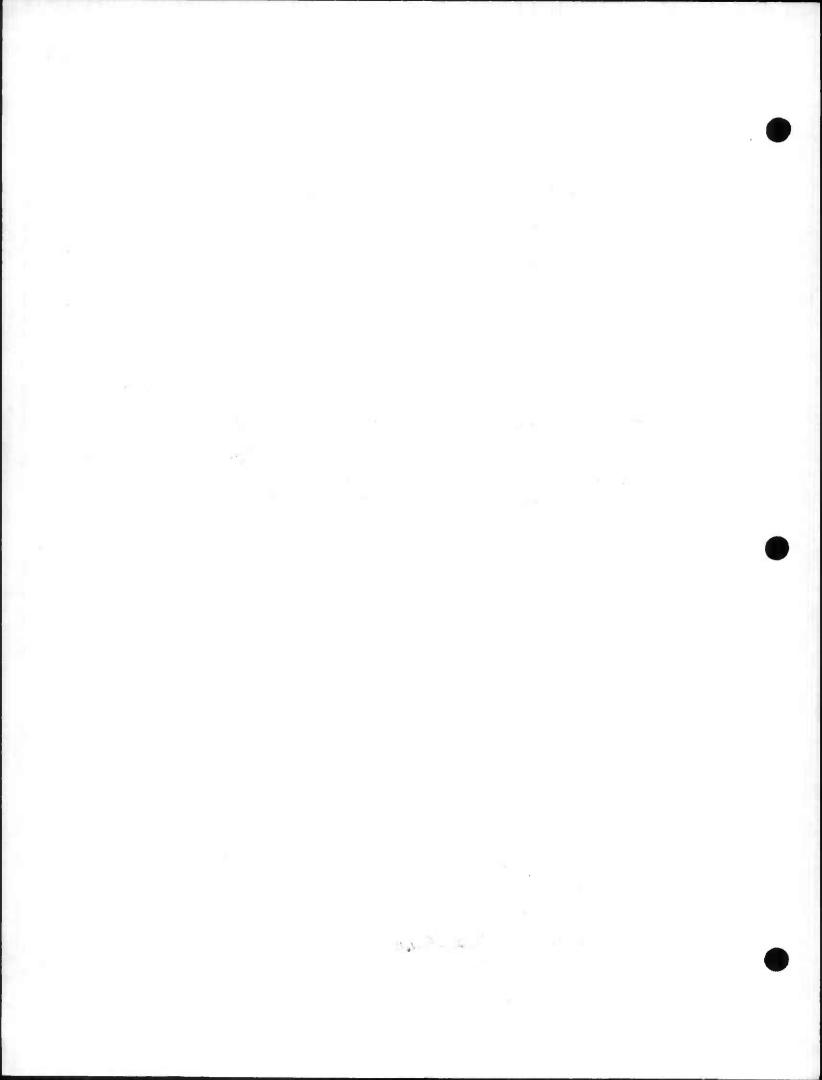
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	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after 6	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the 1 be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical ex
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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH BEG NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF CEATH December 14, 1995 Dwight Richardson 2:50 P 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH (Month, Day, Year) IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign 213-64-5466 1 X M 2 - F 8-7-195 MARYLAND Se. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH Maryland General DIRECTOR Hospital Baltimore City Baltimore City RESIDENCE OF DECEDENT 10b. COUNT 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY BALTIMORE MARYLAND 1 XYES 2 NO FUNERAL 10e. STREET AND NUMBER 101 ZIP CODE 10a, CITIZEN OF WHAT COUNTRY? #2c 1911 EUTAW KL UNITED 21217 STATES 12. WAS OECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yas or No—
If yes, specify Cuban, Maxican, Puarto Rican, etc.)
1 ☐ YES 2 ☑ NO Specify: 14. RACE — American Indian, Black, White, atc. 1 Never Married 2 Married BY 3 Widowed 4 Divorced BLACK 16e. DECEDENT'S USUAL OCCUPATION ED 15. DECEDENT'S EDUCATION 165 KIND OF BUSINESS/INDUSTRY (Specify only highe (Give kind of work done life. Do NOT use retired.) ET Elementary/Secondary (0-12) College (1-4 or 5+) HOSPITAL COMPL STATISTICIAN 12 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Malden Surname) JOHN MISSOURI EDNA MAE KICHARDSON 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 SIDNEY M. WATERS TOWNBROOK DR. APT, E : BALTIMORE, MD 21207 20a. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION — City or Town, Stata 1 Burial 2 Cremation 3 Removal from State
4 Donation 6 Other (Specify) cemetery, cremetery or other place! GREEN MOUNT CREMATURY 18-95 BALTIMORE, MD 22. NAME AND ADDRESS OF FACILITY CAFA STEPHEN D. LOHRMANN P.A. 21. SIGNATURE OF FUNERAL SERVICE LICENSE 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. 21286 BALTIMARE, MD: 8717 GREEN PASTURES DE Approximate Interval Between **Onset and Death** IMMEDIATE CAUSE (Finel disease or condition Immune Thrombocytic Purpura resulting in death) DUE TO (OR AS A CONSEQUENCE OF). AIDS End Stage CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF) If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated eventa resulting in death) LAST PART II. Other aignificent conditions contributing to death but not resulting in the underlying ceuse given in Part i. 24s. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS MEDICAL AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? Seizure Disorder 1 - YES 2- NO 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES IN NO INCERTAIN I PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) HOSPITAL:
1 Vinpetient 2 ER/Outpetient 3 DOA OTHER:
4 | Nursing Home 5 | Residence 6 | Other (Specify) I YES 2 NO 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK?
1 YES 2 NO 28b. TIME OF 28d. DESCRIBE HOW INJURY OCCURED 1 X Natural 5 Pending ВУ 2 Accident 3 Suicide 28e. PLACE OF INJURY — At home, farm, straet, factory, offica building, etc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town State) 6 Could not be determined COMPLETED 4 Homicide 29a. CERTIFIER
(Check only one)

29a. MEDICAL EXAMINES: On the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On the basis of axamination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(a) and manner as stated. 29b. SIGNATURE AND TITLED AND TITLED 29d. DATE SIGNED (Month, Day, Year) 29c, LICENSE NUMBER BE ▶ December 15,1995 2 36. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type. Print) Harsh Bhushan, M.D. c/o Maryland General Hospital

OHMH-16 Rev 1/89



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible, State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Nema (First, Middla, Last) 2. Dete of Death 3. Tima of Death **Physician** 15 1995 DEC. JR. JAMES ROBINSON 8:40 AM /Medical 4a. Fecility Nama (If not Institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1103 N.GILMOR STREET n/a BALTIMORE 5. Sociel Security Numbe 218-78-8808 7. Aga (In yrs. last birthdey) If Under 1 Yeer If Under 24 Hrs.

Months Days Hours Min. 8. Dete of Birth 9. Birthplace (State or Foreign BAUMTY MORE, MD **Funeral** Days 1 X M 2 F Yrs. Director Usual Rasidance of Decedant with the Maryland 10e. State 10b. County 10c. City, Town or Location BALTIMORE, 10d. Insida City Limits 28a-f show 7 is marked other than "natural; or items 23s or 28s-f sho traumatic event, the Modical Examition must be included MD. n/a XXYes 2□No Director 10g. Citizan of What Country? UNITED STATES 10e. Street end Number 10f. Zlp Coda 21217 GILMORE STREET 1115 238 Funerai filed within 72 hours after death Wes Decedent Evar In U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yas or No-If Yas, specify Cuben, Mexican, Puerto Rican, etc.) 11. Meritel Status 14. Race - Amarican Indian, Bieck, Whita, etc. XNevar Married 2 ☐ Married 1 ☐ Yes 2) ☐ (No If Yas, Giva Yaer or Detes: Maryland 21215-0020 1 ☐ Yas X2 No Specify Specify: BLACK þ 3 Widowed 4 Divorced "natural", Completed 16a. Decedant's Usual Occupation (Give kind of work done during most of working lifa. DO NOT usa ratired) 15. Decedant's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiena. Elementary/Secondary (0-12) Coilaga (1-4or 5+) HANDY MAN SELF EMPLOYED permit. Pages 1 and 2 should be filed.
Department of Health and Mental Hygi Important: If Item 27 is marked other any Injury or other traumers. 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maiden Sumama) Be DOLORES BESSICK JAMES Α. ROBINSON SR. 2 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) BALTIMORE ST. APT.805, balto., MD # 23 DOLORES ROBINSON 1010 W. Baltimore. 20b. Placa of Disposition (Nama of cematery, crematory or other placa) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata XXBurial 2 Cramation 3 Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Specify) KING MEMORIAL PARK 12-19-95 RANDALLSTOWN, MD 21. Signatura of Funaral Sarvice Licenses 22. Neme end Address of Fecility 23a. Pent1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List *on*ly one cause on each line. E. NORTH Approximate Interval Between Onset and Death **Physician** /Medical immediata Causa (Final disaasa or condition rasulting In death) Arteriosclerotic Cardiovascular Disease Examiner Dua to (or as a consequence of): Examiner Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if any, leading to Immadiata cause. Enter Underlying Causa (Disease or Injury that initiated events rasulting In death) Lest pue Dua to (or as a consequence of): Box 68760, physician Physician/Medicai the Dua to (or es e consequança of) ed by the attending detached for use as Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. 23b. Did tobacco use contribute to the cause of death? signed by t 1 ☐ Yes 2 ☒ No 3 ☐ Probebly 4 ☐ Unknown Diabetes Mellitus þ 24b. Wara autopsy findings available prior to completion of cause of death? Completed 24e. Was an autopsy performed? peed certificate has 1 ☐ Yes 2 X No 1 Yas 2 No Division of Vital al or Attending Physicien: 1 s after death. Il Director: After this certifical ed in by the funeral director, p Be 25. Was casa rafarred to medical axaminar? 26. Placa of Death (Check only ona) home Other: 4 Nursing Homa 5 Rasidence Whithar (Specify) friend Certification: To 1 Yas 2 No 1 Inpatiant 2 ER/Outpatient 3 DOA 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28d. Dascribe how injury occurred 28b. Tima of 28c. Injury at Work? 5 Panding Invastigation 1 Naturai 1 ☐ Yas 2 ☐ No 2 Accident 3 Suicida 6 Could not be datarmined 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Spacify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 4 Homicida To the Hospital or within 24 hours at To the Funeral Di completely filled i 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or invastigetion, in my opinion, death occurred et the time, date end place, and due to the cause(s) end menner stated. 29a. Certifian Medical 29b. Signeture end titla of certifiar 29c. License number 29d. Dete signed (Month, Dey, Year) and this of certifier Wright MD DECEMBER 15,1995 O.C.M.E.

State Registrar 31. Date filed (Month, Dey, Year) DEC1 91995

for

Mario F. Golle Jr. M.D. 111 Penn Street, Baltimore, Maryland 21201 32. Registrar's Signatura In Shutteer Reviel

30. Name and addrass of person who complated cause of daeth (Itam 23a) (Type, Print)

DIVISION OF VITAL RECORDS, P.O. BOX 68760

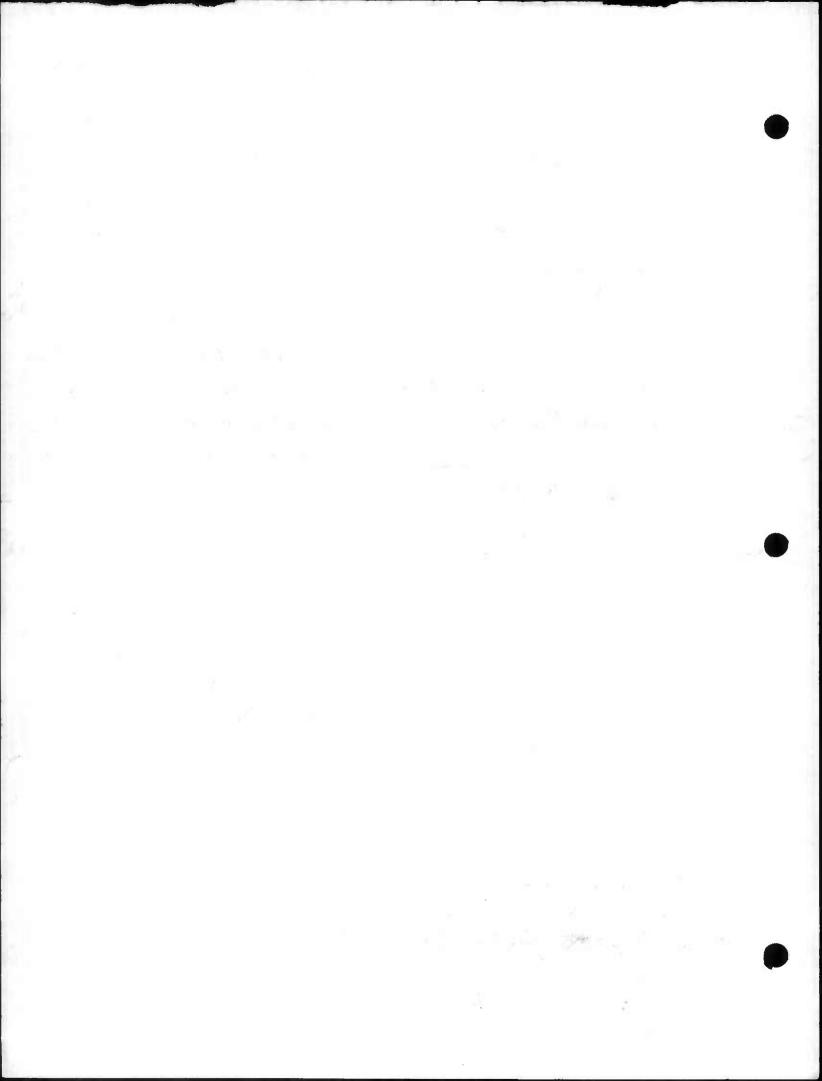
		ITEM: 2. PER F.H. FILM G-730 12/19/95 t.t		95 3	8283
		1 - STATE OF MARYLAND / DEPARTMENT OF HEALTH A CERTIFICATE OF DEATH			
		1. DECEDENT'S NAME (First, MIDDIR, Last) Richardson	2. DATE OF DEAT		924 P M
√ □		4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. leet birthdey) IF UNDER 1 YEAR IF UNDER 2. 214-44-54-35 1 M 2 - F 4 9 YRS. MONTHS DAYS HOURS	MIN. 7. DATE OF BIRTH (Month, Day, Year MAR, 14	a. BIRTHP Gountry)	RV LAND
2, 3 should	TOR	98. FACILITY NAME (IV not institution, give street and pumber) 98. CITY, TOWN OR LOCATION UNIVERSITY OF MARY LAND BALLINGS	NOF DEATH C, MD	9c. COUNTY OF DEA	АТН
permit, Pages 1.	DIRECTOR	MARYLAND NA BALTIMOA	RE		10d. INSIDE CITY LIMITS? 1 X YES 2 NO
usit	FUNERAL	100. STREET AND NUMBER 101. ZIP CODE	1223	10g. CITIZEN OF WI	
215-0020 attending physician. Ise as the burial-transit	BY FUR		F HISPANIC ORIGIN? (Specif , Mexican, Puerto Rican, etc Specify:		— American Indian, White, etc.
	8	15. DECEDENT'S EDUCATION (Specify only highest grade completed) (Give kind of work done during most of working life. Do NOT use retired.)		F BUSINESS/INDUSTRY	ACK
D Spital ed to	COMPLET	UNKNOWN College (1-4 or 5+) FITTER Y THREAD		240 VENETI	AN BLIND CO
YLA by the be de	BE CO	ARKEY RICHARDSON GE	ER'S NAME (First, Middle, Me RTRUDE		NON
MA retain 5 sho 6 sho	10	190. INFORMANT'S NAME (Type/Print) SVLVESTER RICHARDSON 153 S, MORLEY		TOWN, State, Zip Code)	21229
MORE, age 6 may be director, page er must be		20a, METHOD OF DISPOSITION 1	DATE 20	c. LOCATION City or Tow	LLE, MD.
Page al dire		TI. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS			/
BALT s after death. by the funer removal. dical exami		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dyin			, MD.21223
24 hours filled in on, or n		immediate Cause (Final disease or condition resulting in death) s. Matcustatic Lung (and	_		interval Between Onset and Death
6876C xecuted within and completely burial, crempti natic event, t	Z	DUE TO (OR AS A CONSEQUENCE OF):		Y	
OX e be es sician a prior to traum	CATIO	Sequentielly list conditions, If sny, leading to immediate cause. Enter UNDERLYING			
O O Hygier Hygier of	CERTIFICATION	CAUSE (Disease or injury that initiated events resulting in death) LAST			
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上年 ste m	PHYSICIAN:	EXAMINER? 1 YES 2 OA Inpetient 2 ER/Outpetient 3 DOA 4 Nursing Home 5 Rea	aldence 6 Other (Specify)	
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DIVISION OR ATTENDING IDIRECTOR: After hours after death item 28 is man	red BY	2 Accident Investigation 3 Suicide 6 Could not be determined 26s. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	261. LOCATION (S City or Town,	treet and Number or Rural Ro State)	oute Number,
DIV TAL OR A ML DIREC 72 hours H Item	COMPLET	29s. CERTIFIER (Check only CERTIFYINO PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place,	and due to the cause(s) and	d menner as stated.	10.1
THE HOSPITAL THE FUNERAL filed within 72 PORTANT: If		2 MEDICAL EXAMINER: On the basis of axamination and/or investigation, in my opinion, death occurs 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICE!	nd at the time, date end place		
TO THE HOSP! TO THE FUNER be filed within	TO BE	audil form PZC	57733	≥ 12/Q	195
		30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)			

30. NAME AND ADDRESS OF PERSON WHO CON ANGELA BROWN M.D. 22 S. GREENE ST. BALTIMORE, MD #21201

2. REGISTRAR'S SIGNATURE

ALLA DEVELOP REALLY STREET 31. DATE FILED (Month, Day, Year)
DEC 1 91995

OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospita	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detaiched	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene phor to burial, cremation, or removal.
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_	1 - STATE REGISTRAR	STATE OF I	MARYLAND C	/ DEPAI ERTIF					MENT	AL HYGIEN REG. NO.			
	1. OECEDENT'S NAME (First, Middle, Last) CHARLOTTE E	loise		SCHA	EFEF	1			2. DAT	Dec 15	1995	YEAR	3. TIME OF DEATH 12:35 pm
	4. SOCIAL SECURITY NUMBER 217-22-5180	5. SEX	6. AGE (In yrs. le	YRS.	IF UNDER	DAYS	IF UNDE	R 24 HRS.		E OF BIRTH		e. BIRTH	PLACE (State or Foreign
TOR	Saint Joseph Medic RESIDENCE OF DECEDENT							or of di				NTY OF D	
DIRECTOR	Maryland Balt:	_			ther								10d. INSIDE CITY LIMITS? 1 YES 2 NO
FUNERAL	100. STREET AND NUMBER 1505 Sherbrook Roa					2	21P COC 1093				U.	S.A.	vHAT COUNTRY?
B	1 Never Married 2 Married 3 Widowed 4 Divorced	FORCES?	FT EVER IN U.S. AI YES 2353 MAR OR OATES			If yes, sp	elfy Cubi	OF HISPAI an, Mexica Specify	n, Puerte	BIN? (Specify Yes o Rican, etc.)	or No-	Speci Whit	E — American Indian, c, White, atc. fly: CC
PLETED	15. OECEDENT'S EDUC (Specify only highest grade Elementary/Secondary (0-12)	CATION completed) College (1-4 or 8	+)	ECEDENT'S Give kind of B. Do NOT u	work done			ng		Real Es			rempler
at once.	17. FATHER'S NAME (First, Middle, Last) Charles O'Connor Ada (unknown)												
TO B	19e. INFORMANT'S NAME (Type/Print) Mr. Richard B. Schaefer 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) same as #10a - #10f												
or must b	20b. METHOD OF DISPOSITION 1 Burlet 2 Cremetton Burlet 2 Comparison Burlet 2 Comparison Burlet 2 Comparison Burlet 2 Comparison Burlet 2 Comparison Burlet 2 Comparison C												
i examin	Santes I. John	St / 111			R1	ack '	Tows York	on F	uner , To	al Homo	Mary]	and	21204
injury, or other traumatic event, the medical examiner must be notified at once. AL CERTIFICATION TO BE COM	23. PART I. Enter the diseases or complications that ceused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart fellure. List only one ceuse on each line. IMMEDIATE CAUSE (Finel disease or condition resulting in death) HEPATO-RENAL SYNDROME DUE TO										Approximats Interval Between Onset and Death 1 WEEK		
on one	DUE TO (OR AS A CONSEQUENCE DF): LIVER CIRRHOSIS DUE TO Sequentially list conditions.										2 YEARS		
r other traumatic	If sny, isading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events	DUE TO (OR AS A CONSEQUENCE OF): HEMOCHROMATOSIS OUE TO (OR AS A CONSEQUENCE OF):										YEARS	
L CERT	PART II. Other significant conditions contributing to deeth but not resulting in the underlying ceuse given in Part I. 24s. WAS AN AUTOPSY 24b. WER												
	TAIT II. Ottor symmetric conditions	contributing to	Geeth but not	reaulting	in the un	iderlying	CeUse	given in	Part I.	PERFOR	MED?	24b.	WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
SICIAN: MEDIC	DID TOBACCO USE CONTR 25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:		CE OF DEA		only one)	UNC	ERTAIN	v 🗆				
PHYS	1 YES 2 400 27. MANNER OF DEATH 1 Netural 5 Pending Investigation	26a. DATE OF (Month, D	INJURY	26b. TIM	4 🗆 Nun	28c. INJI WO	JRY AT			er (Specify)	JURY OCC	CURED	
# O	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide datarmined	28a. PLACE Obuilding,	F INJURY — Al ho atc. (Specify)	ome, farm,	street, fact	ory, office			281. LO Ch	CATION (Street a y or Town, State)	nd Number	or Rural A	oute Number,
ANT: If item 28 COMPLETE	20a. CERTIFIER 1 CERTIFYING PHYSIC (Check only one) 2 MEDICAL EXAMINER												and manner as stated.
TO BE COM		. cle Les			Print)		_	950 9				A	(Month, Day, Year)
	NATIVIDAD D. DEL 31. DATE FILED (Month, Day, Year)	EON M.[D. ST. JO	DSEP		DICA	L CEI	NTER	TOV	VSON, M	D. 212	204	
	DEC1 9 1995	Juli du	valuar Rain	alf									

BALTIMORE, MARYLAND 21215-0020 after death. Page 6 may be retained by the hospital or attending physicis

TO THE HOSPITAL DR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

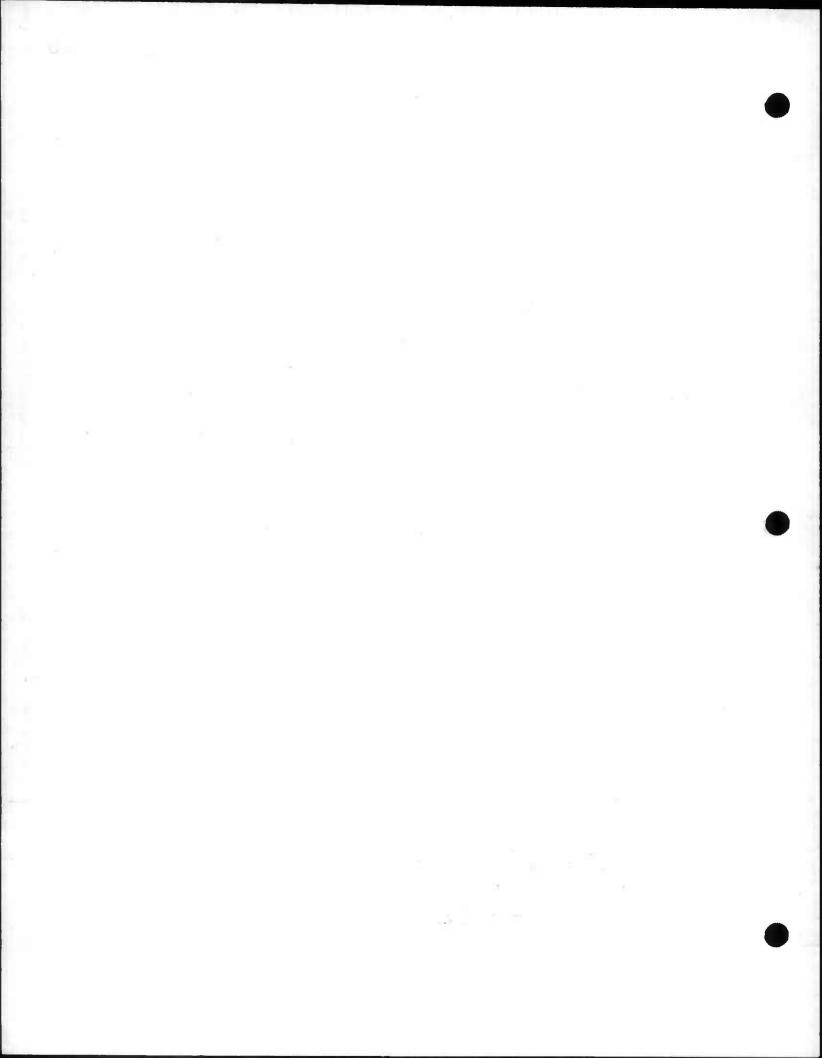
IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, P.O. BOX 68760

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

									TIEG. NO.				
)	1. DECEDENT'S NAME (First, Middle, Last) VERNA	M.		SMI	TH				2. DATE OF DEATH	1992	ar //:50 P M		
j	4. SOCIAL SECURITY NUMBER 238-56-9198	5. SEX	6. AGE (In yrs. lest	t birthday) YRS.	IF UNDER MONTHS	t YEAR DAYS	HOURS	24 HRS. MIN.	7. DATE OF BIRTH (Month, Day, Year)		BIRTHPLACE (State or Foreign Country)		
	9a. FACILITY NAME (If not institution, give st	treet and number)			9b. CITY,	TOWN	OR LOCATI	ON OF DE		9c. COUNTY	OF DEATH		
DIRECTOR	GUOD Samarit		Ba	11/1	more	/		NA					
<u> </u>	10e, STATE 10b, COUNTY	,		10c. CIT	Y. TOWN O	, TOWN OR LOCATION					10d, INSIDE CITY		
	Md	NA		B	Baltimore					LIMITS?			
FUNERAL	1945 Waver	-ly W	aus			101. ZIP CODE 10g. C					og. CITIZEN OF WHAT COUNTRY?		
5	11. MARITAL STATUS		T EVER IN U.S. AR				CENDENT (OF HISPAN	HC ORIGIN? (Specify Yes	or No- 14.	RACE — American Indian,		
BY	1 Never Married 2 Married 3 Midowed 4 Divorced FORCES? 1 YES 2 Midowed 4 Divorced If YES, GIVE WAR OR DATES IT YES 2 Midowed 1 Divorced It yes, specify Cuban, Maxican, Puerto Rican, etc.) It yes, specify Cuban, Maxican, Puerto Rican, etc.) 1 YES 2 Midowed Specify: Specify: Black												
	15. DECEDENT'S EDUC (Specify only highest grade	CATION completed)	/G/	we kind of	Work done	CCUPATI	ION lost of worki	ng	16b. KIND OF BUS	SINESS/INDUST	RY		
PLET	Elementary/Secondary (0-12)	College (1-4 or 5	+) D	DO NOT U	1 .				Hon	ne			
COMPL	17. FATHER'S NAME (First, Middle, Last)			1100			18., MOT	HER'S NA	ME (First, Middle, Melden,				
BE	William Chai	nce	II 165				Ko	utie	Ormand				
10	190 INFORMANT'S NAME (Type/Print)	Bond	191	5 9 1	ADDRESS	S (Street	and Numbe	(1)	Poute Number, City or Town	alto me	1 21239		
	20e/METHOD OF DISPOSITION 1 Burlel 2 Cremetion 3 Reme 4 Donation 6 Other (Specify)	oval from Stata	20b. PLACE /	AND DATE	DATE OF DISPOSITION (Name of professional form) DATE 20c. LOCATION - City or Town, State 12/21/95 Bell Haven N.C.								
	21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEE			22.	NAME A	ND ADDRE	SS OF FA	CILITY +		- '		
	> Duns	15. J	arris	ン		+3	00	Wo	abash Are	nue 1	Balto, red 21215		
	23. PART Enfer the diseases, or o shock, or heart fellure.	List only one car	use on each line),						ratory arrest	Approximata Interval Between Onset and Dasth		
_				A CONSEQUENCE OF:							VENOS		
RTIFICATION	Sequentielly list conditions, if sny, leeding to immediate	DUE TO	(OR AS A CONSEC	DUENCE O	F):			/			/CAN)		
CA	cause. Enter UNDERLYING CAUSE (Disease or Injury		NOWARY			IE	NSTO	M			YEKRS		
	that initiated events resulting in death) LAST	DUE TO	(OR AS A CONSE	DUENCE O	HF):								
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AL	PART il. Other significent condition	s contributing to	deeth but not r	esulting	in the ur	nderiyli	ng ceuse	given in	Part I. 24a. WAS AN PERFOR		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO		
DICA									1 🗆 YES 2	NO	COMPLETION DF CAUSE OF DEATH?		
ME	DID TODA GGG LIGH GG: T	DIDLITE TO S	LIGH CT TO	milita di minin		100 5	7			_	1 - YES 2 NO		
CIAN	DID TOBACCO USE CONTI	KIBUIE TO CA			ES			CERTAI	N/LI				
S	EXAMINER? 1 YES 2 NO	HOSPITAL:			OTHER	R:							
PHYS	27. MANNER OF DEATH	28e. DATE O	ER/Outpetlant 3	28b. TIR			me 5 ∐ R	esidence	6 Other (Specify) 28d, DESCRIBE HOW I	NJURY OCCUR	ED.		
	1/ Netural 5 Pending	(Month, I			JURY	W	ORK? YES 2	_ NO					
D 8Y	3 Suicide 8 Could not be	26e. PLACE (OF INJURY — At he	me, term,	street, fect	tory, offi	Ica		28f. LOCATION (Street a City or Town, State)		Rural Route Number,		
COMPLETE	4 Homicide determined												
7		CIAN: To the best o	f my knowledge, de	eth occur	red at the t	ilme, dat	te and place	e, and due	to the cause(a) and man	ner as stated.			
Š O	one) 2 MEDICAL EXAMINE	R: Dn the basis of	exemination and/or	Investigati	on, in my c	opinion,	death occu	ired at the	time, data and place, an	d due to the co	suse(a) and manner as stated.		
BE	29b. SIGNATURE AND TITLE OF CENTIFIE	A ILANA	a - CTM	_			29c. LIC	ENSE NUI	MBER	29d. DATE SI	GNED (Month, Day, Year)		
2	30. NAME AND ADDRESS/OF PERSON WH	NUUS	STUDIAL	1	- Dr/		P	075	000	· NO	- 4,1945		
	GAMAKIEL	P. BAT	ALLA	M	10 -	GO	00 5	MI	ARITAN	HOST	21742		
	" " " UEU 1" 9 1995 J	32 REGISTR	AR'S SIGNATURE										





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ending physician and completely filled in Hygiene prior to burial, cremation, or

attending physician

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DIVISION OF VITAL RECORDS, P.O. BOX 68760	SPITAL OR ATTENDING PHYSICIAN;
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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Leat) 2. DATE OF DEATH 3. TIME OF DEATH MYRTLE **EMMA** DECEMBER 13, SCHLAG 1995 9:30 P. 4. SOCIAL SECURITY NUMBER 7. DATE OF BIRTH (Month, Day, Year) 06-24-1905 5. SEX 6. AGE (In yrs. lest birthday) IF UNDER 1 YEAR | IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign 213-42-2681 90 HOURS 1 M 2 K F MARYLAND as. FACILITY NAME (If not institution, give atreet and number) NORTH ARUNDEL NURSING & REHABILITATION CENTER 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR GLEN BURNIE ANNE ARUNDEL RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MARYLAND ANNE ARUNDEL GLEN BURNIE 1 YES 2 NO FUNERAL 10e, STREET AND NUMBER 101, ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 6660 SHELLEY ROAD 21061 U.S.A. 11 MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 X NO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-14. RACE — American Indian, Black, White, etc. FORCES? 1 YES 2 If yes, specify Cuban, Maxican, Puarto Rican, etc.)

1 YES 2 NO Specify: 1 Never Married 2 Married Specify: WHITE BY 3√ Widowed 4 □ Divorced Specify: 16a. DECEDENT'S USUAL OCCUPATION COMPLETED 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only high (Give kind of work done during life. Do NOT use retired.) lary/Secondary (0-12) College (1-4 or 5+) 12 N/A OPERATOR TELEPHONE COMPANY 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) ALFRED FLAYHART FRANCES FIEND BE notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5 DARLENE C. McMAHON 2655 OGLETON ROAD, ANNAPOLIS, MD. 21403 3 20s. METHOD OF DISPOSITION
12 Burial 2 Cremation 3 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State must 2619 PARKWOOD CEMETERY 4 Donation 8 Dother (Special) BALTIMORE, MARYLAND examiner 21. SIGNATURE OF PUNERAL SHIPPICE LICENSEE 22. NAME AND ADDRESS OF FACILITY SINGLETON FUNERAL HOME, 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061 medicai 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, Di heart failure. List only one cause on each line. Interval Between IMMEDIATE CAUSE (Final Onset and Death the disease or conditio 07 mu event. resulting in death) DUE TO (OR AS A CONSEQUENCE OF): abites traumatic CERTIFICATION Sequentially list conditions, if any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF): cause. Enter UNDERLYING CAUSE (Disease or Injury other DUE TO (OR AS A CONSEQUENCE OF): that initiated events regulting in death) LAST 6 PART II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. MEDICAL 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? shows any 1 TYES 2 NO 1 TYES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: 3 28. PLACE OF DEATH (Check only one) 25. WAS CASE REFERRED TO MEDICAL item HOSPITAL: Name of Residence 8 Other (Specify) 1 TYES 2 NO 1 Inpetient 2 ER/Outpetient 3 DOA 28a, DATE OF INJURY 27. MANNER OF DEATH 28c. INJURY AT 28d. DESCRIBE HOW INJURY OCCURED marked, 1 Matural 5 Pending DIRECTOR: After the hours after death vitem 28 is mark 1 YES 2 NO BY Investigation 2 Accident 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 3 Sulcide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 8 Could not be COMPLETED 4 Homicide TO THE HOSPITAL OR AT
TO THE FUNERAL DIRECT
DE filed within 72 hours a
IMPORTANT: If Item 2 29a. CERTIFIER
(Check only one)

2 MEDICAL EXAMINER: On the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated. 2 MEDICAL EXAMINER: On the basis of exemination and/or in tion, in my opinion, death occured at the time, data and place, and due to the cause(s) and menner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year)

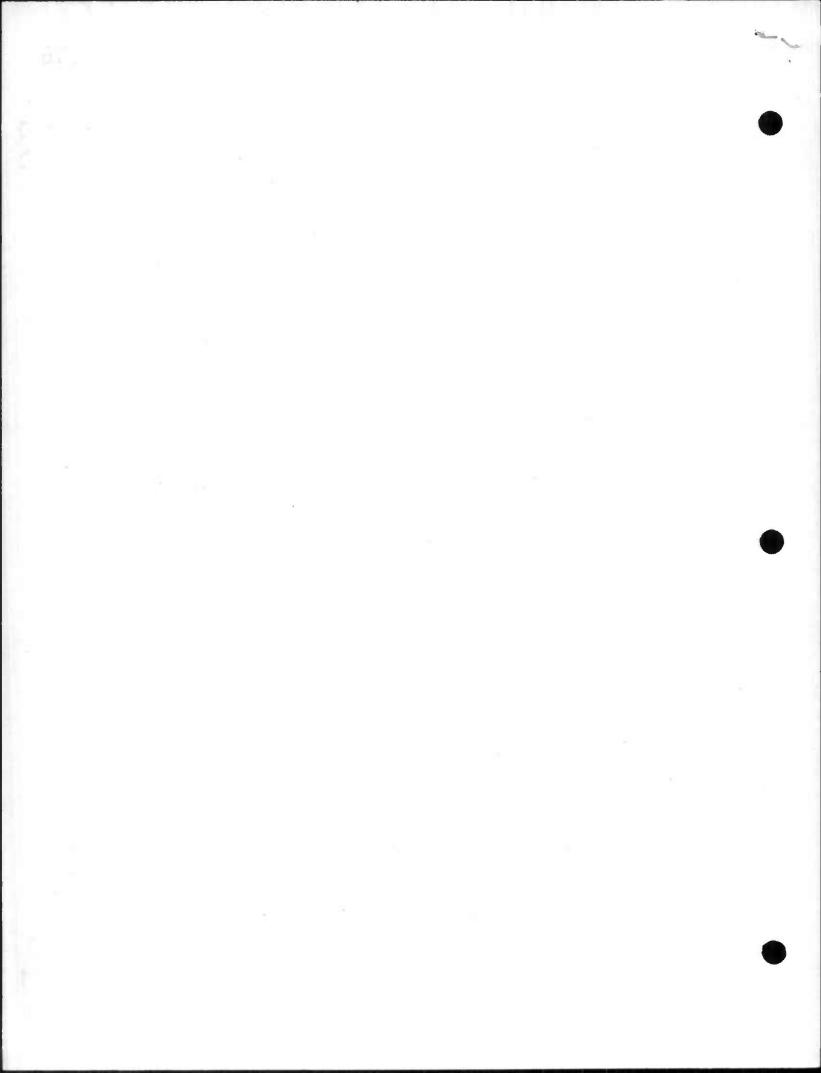


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30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH ITEM 27

32. REGISTRAR'S SIGNATURE

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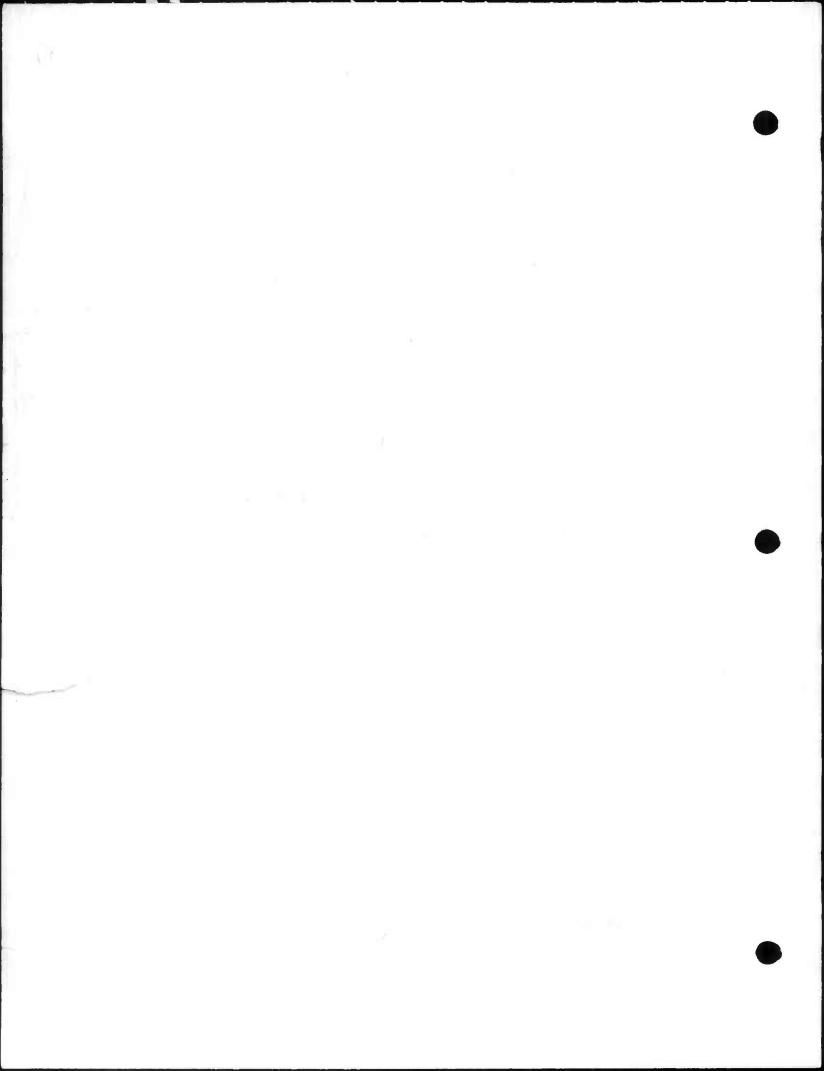
BOX 68760 BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within Z4 hours after death. Page 6 may be retained by the hospital or artending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	WPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	
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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH
REG. NO.

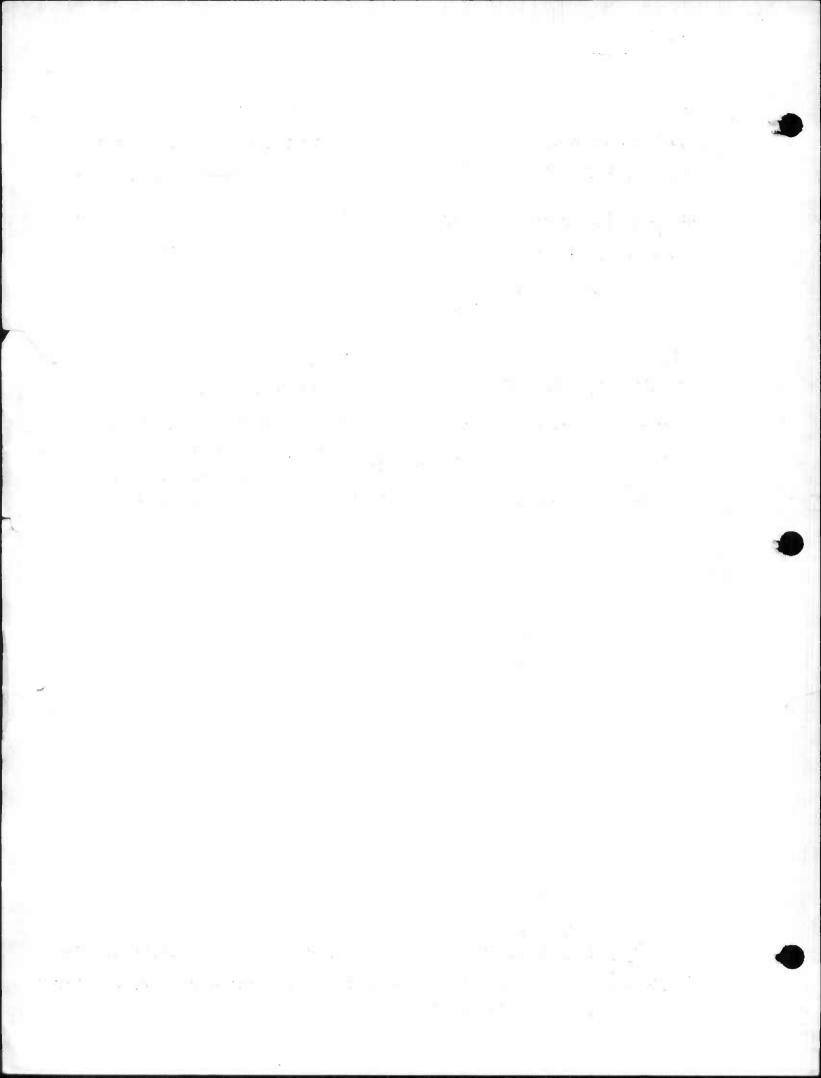
	REGISTRAR		CER	TIFIC	ATE OF	DEATH	F	REG. NO.			
	1. DECEDENT'S NAME (First, Middle, Last) MELV(V)	John	5410	VK	A		2. DATE OF	DEATH DA		YEAR 45	3. TIME OF DEATH 12=15/M
3	4. SOCIAL SECURITY NUMBER 212 09 2461	5. SEX 8. 1 XM 2 F	AGE (In yrs. lest birt	thday) IF	UNDER 1 YEAR WITHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF (Month, D. 08 04	BIRTH by, Year) 12		Country)	vland
OR	96. FACILITY NAME (If not Institution, give st Church Hospita	reet end number)		96. COUNTY Baltimore Pc. COUNTY N/A						NTY OF DE	*
5	RESIDENCE OF DECEDENT										
FUNERAL DIRECTOR		/A	10		imore				10d. INSIDE CITY LIMITS? 1 YES 2 NO		
VERAL	435 Folcroft St	reet		101. ZIP CODE 21 224					USA		IAT COUNTRY?
B	11. MARITAL STATUS 1 Never Married 2 Merried 3 Widowed 4 Divorced	YER IN U.S. ARMED YES 2 NO OR DATES	2 NO If yes, specify Cuben, Mexican, Puerto Rici			N? (Specify Yee or No— 14. RACE — American, etc.) 14. RACE — American, etc.) Specify: White			White, atc.		
	15. DECEDENT'S EDUC		16a, DECEDI	ENT'S USU	AL OCCUPAT	ON	185 178	NO OF BUILD	INESS /INF	MICTOV	
COMPLETED	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4 or 8+)	(Give ki life. Do i	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use refired.) Fire Fighter 16b. KIND OF BU Balti:				www.coms			
3	17. FATHER'S NAME (First, Middle, Last)					18. MOTHER'S NA					
BE C	Alexander Sli	wka				Anna	Wolins	ki	,		
2	190. INFORMANT'S NAME (Type/Print) Genevieve A.Sli	wka	19b. MA	35 Fo	olcrof	end Number or Rural t St. Ba	Poute Number, 1to., M	d.	, State, Zip	Code)	
	20a. METHOD OF DISPOSITION 1	wal from Stata	cemetery, cremato	CEANDDATE OF DISPOSITION (Name of crematory or other place) V ROSary Cemetery 12-14-95 DATE 20c. LOCATION — City or Town, State Dundalk, Md.							n, State
	21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEE A	10.		22 NAME A	NO ADDRESS OF FA	CILITY				
	23. PART I. Enter the diseases, or c	N. Ja	~~~		6224	Eastern	Ave.	Balto	o.Mo	d.	
	ahock, or heart failure. I	i. PNB	AS A CONSEDUEN	1/1/2						,	Approximata interval Between Onaet and Death
CERTIFICATION	Sequentially list conditions, If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury c										
ERTIF	that initiated events resulting in death) LAST	DUE TO (DR	AS A CONSEQUEN	ICE OF):							
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EDICAL		TR				g cause given in		PERFORI	MED?		VERE AUTOPSY FINDINGS WAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATN?
Σ	DID TOBACCO USE CONTR	IBUTE TO CAUS	E OF DEATH	YES [] NO [UNCERTAI	N Ø			1	YES 2 NO
3 II	25. WAS CASE REFERRED TO MEDICAL EXAMINER?		26. PLACE OF	_							
š	1 TES 2 TO NO	HOSPITAL:	/Outpatient 3 🗆 D		HER: Number Nor	ne 5 🗆 Residence	8 Other (Co	nec/ful			
Y PHYSICIAN:	27. MANNER OF DEATN 1 Natural 5 Pending Investigation	28e, DATE OF INJ (Month, Day, Y	JRY 286	b. TIME OF INJURY	28c, IN	PURY AT DRK? YES 2 NO	28d. OESCRI		JURY OC	CUREO	
red BY	2 Accident Investigation 3 Suicide 8 Could not be determined	28e. PLACE OF IN building, etc.	JURY — At home, f (Specify)	farm, street			281. LOCATION (Street end Number or Rural Route Number, City or Town, Stete)				ite Number,
щ	29e. CERTIFIER										
COMPLET	(Check only one) 1 CERTIFYING PNYSIC (Check only one) 2 MEDICAL EXAMINER										and manner es stated.
ᇤ	29b. SIGNATURE AND TITLE OF CERTIFIER	emi s	20			29c. LICENSE NUI		,			Aonth, Day, Year)
2	30. NAME AND ADDRESS OF PERSON WHO		F DEATN (ITEM 27)	(Type, Print) fr	H H	111			4,1	111775
	31. DATE FILED (MONTH OF, 1 pr) 9 199	5 32. 6695 Thurs	SIGNATURE ROM	C61	Unc	H H	ISALI	7	ng	.21	231
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State Registrar DEC 1 6 1995

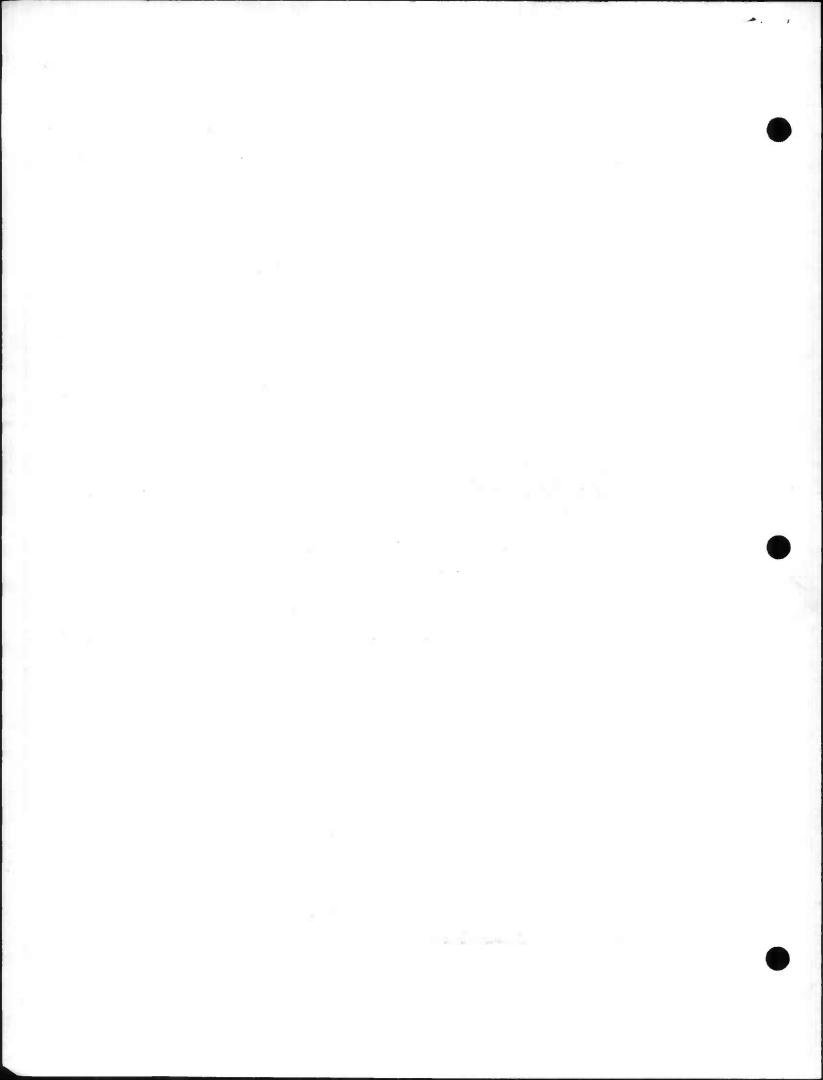
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S. Wolfe W) 111 Penn Street, Baltimore, Maryland 21201



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TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hosp	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detache	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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HO.	F	WIL	HTA
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1 - FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYD REGISTRAR CERTIFICATE OF DEATH	GIENE	
1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF OE.	ATH	3. TIME OF OEATH
KERN ALBERT SUNDERLAND, JR. Decemb		95 1:45 A M
4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. OATE OF BIR	TH I	B. BIRTHPLACE (State or Foreign
218-22-8009 1 X M 2 D F 68 YRS. MONTHS DAYS HOURS MIN. JULY 6, 9a. FACILITY NAME (# not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH	1927	Maryland TY OF DEATH
The state of the s		N/A
5915 Bertram Ave. RESIDENCE OF DECEDENT 100. STATE 100. COUNTY 100. CITY, TOWN OR LOCATION		10d. INSIDE CITY
Maryland N/A Baltimore City		1 💢 YES 2 🗌 NO
100. STREET AND NUMBER 5915 Bertram Ave. 21214		I.S.A.
11. MARITAL STATUS 1 Never Married 2 Married 1 Never Married 2 Married 3 Widowed 4 Divorced 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 X YES 2 NO If yes, specify Cuben, Marken, Puerto Rican, 4 In YES 2 NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed) 16a. DECEDENT'S USUAL OCCUPATION (Sive kind of work done during most of working) 16b. KIND	OF BUSINESS/INDU	STRY
Elamentary/Secondary (0-12) College (1-4 or 5 +) 10 Yr 's Chauffuer Ruck	Funeral	Homes
10 Yr's Chauttuer Ruck 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle),	Maiden Surname)	
Kern A. Sunderland Florence	Wegwort	h
196. INFOHMANT'S NAME (Type/Print) 196. MAILING ADDRESS (Street and Number or Rural Route Number, City	or Town, State, Zip (Code)
Mrs. Stella Sunderland same as #10		
20e. METHOD OF DISPOSITION 1 & Burlat 2 Cremation 3 Removal from State 4 Donation 6 Other (Specify) Date 20b. PLACE AND DATE Of DISPOSITION (Name of cemetery, crematory or other piece) Parkwood Cemetery 12/21/95	Raltimor	
		1D 21214
	•	
Leonard J. Ruck, Inc. 23. PART I. Enter the diseases, promplications that caused the death. Do not anter the mode of dying, such as cardiac or		
shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition	rospilatory arro	Interval Batween Onset and Death
resulting in death) a. ACUTE MYOCARDIAL INFARCTION DUE TO (OR AS A CONSEQUENCE OF):		1 HR.
Sequentially list conditions, HYPERTENSION Due to (or as a consequence of):		l YR.
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury CAUSE (DISEASE		1 YR.
that initiated events DUE TO (OR AS A CONSEQUENCE OF):		
DIABETES MELLITUS		10 YRS.
	PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE
		AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 -	PERFORMED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE
	PERFORMED?	AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 -	PERFORMED? YES MAN NO	AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 X NO 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 Inpatient 2 ER/Outpetient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Special Number of Death 28s. DATE OF INJURY 2 28b. TIME OF 28s. WORK 2 28d. DESCRIBE	PERFORMED? YES MAN NO	AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 No PITAL: 1 Inperient 2 ER/Outpetient 3 DOA 27. MANNER OF DEATH 1 No No No No No No No No No No No No No	YES 2√ NO	AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 1 Inperient 2 ER/Outpetlem 3 DOA 4 Nursing Nome NORK? 26. INJURY AT WORK? 1 Notural 5 Pending Investigation 27. Matural 5 Pending Investigation	YES 2 NO Ify) HOW INJURY OCCI (Street and Number of	AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 Inpatient 2 ER/Outpetient 3 DOA 4 Nursing Home 1 Realdence 6 Other (Special North) Nursing Home 1 Realdence 6 Other (Special North) Nursing Home 2 Realdence 8 Other (Special North) Nursing Home 2 Realdence 8 Other (Special North) Nursing Home 2 Realdence 8 Other (Special North) Nursing Home 2 Realdence 8 Othe	PREFORMED? YES 2 NO Ify) HOW INJURY OCCI (Street and Number of	AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO URED OF Rural Route Number,
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 Inpatient 2 ER/Outpetient 3 DOA 4 Nursing Home 1 Realdence 6 Other (Special North) Nursing Home 1 Realdence 6 Other (Special North) Nursing Home 2 Realdence 8 Other (Special North) Nursing Home 2 Realdence 8 Other (Special North) Nursing Home 2 Realdence 8 Other (Special North) Nursing Home 2 Realdence 8 Othe	ity) HOW INJURY OCCI (Street and Number of , State)	AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO URED OF Rural Route Number,
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 1 Inpatient 2 EP/Outpatient 3 DOA 4 Nursing Mome X Residence 6 Other (Specify) 27. MANNER OF DEATH 1 Natural 5 Pending Investigation 3 Suicide 6 Could not be determined 28a. DATE OF INJURY At WORK? M 1 YES 2 NO 28a. PLACE OF INJURY At HORK? WORK? M 1 YES 2 NO 28a. PLACE OF INJURY At Home, farm, street, factory, office 28a. PLACE OF INJURY At Home, farm, street, factory, office 28b. LOCATION City or Town 28c. INJURY At WORK? M 1 YES 2 NO 28c. INJURY AT WORK? M 1 YES 2 NO 28c. INJURY AT WORK? WORK? M 1 YES 2 NO 28c. LOCATION City or Town 28c. CERTIFIER (Check only one) 28d. DESCRIBE	ify) HOW INJURY OCCI (Street and Number of, State) India manner as state lace, and due to the	AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO URED OF Rural Route Number, d. couse(s) and manner as stated. SIGNED (Month, Day, Year)
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH (Check only one) 27. MANNER OF DEATH DEATH 1 Notural 1 Pending Investigation 2 Noture 1 Note 1 Noture 1 Note 1	ify) HOW INJURY OCCI (Street and Number of, State) India manner as state lace, and due to the	AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO URED OF Rural Route Number, d. ceuse(s) and manner as stated.
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 1 Inpatient 2 ER/Outpetient 3 DOA 4 Nursing Mome NORK? 1 Natural 5 Pending Investigation 2 Accident 3 Suicide 6 Could not be determined 2 as. DATE OF INJURY At WORK? 28a. PLACE OF INJURY At WORK? 1 YES 2 NO 28a. PLACE OF INJURY At Normaling Mome NORK? 28a. PLACE OF INJURY AT NORMALING NORMALING NORMALING NORMALIN	PREFORMED? YES 2 NO Ify) HOW INJURY OCCI (Street and Number of , State) Ind manner as state lace, and dua to the	AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO URED OF Rural Route Number, d. couse(s) and manner as stated. SIGNED (Month, Day, Year)



DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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	1 - FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPA CERTII	RTMEN	T OF H	EALTH DEAT	AND M	ENTAL	HYGIEN REG. NO.			0023	0
	1. DECEDENT'S NAME (First, Middle, Last)								OF DEATH			3. TIME OF DEATH	1
	AUDRA M SWIF	T					b	ECE	MBER I	4	1995	11:45	
	4. SOCIAL SECURITY NUMBER 5	SEX 6. AGE (EX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS.					7. DATE OF BIRTH 8. BIRTHP			PLACE (State or For		
	217-12-6434 19a. FACILITY NAME (if not institution, give stree	□ M 2X F	74 YRS.	Dec. 0, 1921					Country	Md.			
OR	GREATER BALTIMORE		NTER		WSON		N OF DEAT	TH			NTY OF DI		
EC	RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY		10c. C	TY, TOWN	OR LOCAT	ION						10d. INSIDE CITY	
DIR.	Md. Balti	imore			moni	um						LIMITS?	10
FUNERAL DIRECTOR	100. STREET AND NUMBER 4 Mullingar Ct. #10	01			101	1. ZIP CODE 10g. CITIZ 21093				U.S.A.			
S		2. WAS DECEOENT EVER IN	U.S. ARMED	13.	WAS DEC	ENDENT OF	HISPANIC	ORIGIN	? (Specify Yes	or No-	14. RACE	- American Indias	1.
BY F	1 Never Married 2 Merried 3 Widowed 4 Divorced	FORCES? 1 YES				cify Cuben 2 X NO		Puerto R	lican, atc.)		Black Specifi	, White, etc.	
												White	
COMPLETED	15. DECEDENT'S EDUCAT (Specify only highest grade cor	TION mpleted)	18e. DECEDENT	work done	CCUPATIO	IN st of working	,	16b.	KIND OF BUS	SINESS/INC	USTRY		
Ш	Elementary/Secondery (0-12)	College (1-4 or 5 +)	life. Do NOT	use retired.)				-					
MP	12		Book Ke	eper					A & P				
8	17. FATHER'S NAME (First, Middle, Last)					18. MOTH	ER'S NAME	E (First, M	fiddle, Malden	Sumame)			
BE	George	M€	erson			Ire	ene					Upton	
0	19e. INFORMANT'S NAME (Type/Print)								er, City or Town				
-	Mrs. Ann S. Eller		7 G1	inhur	st G	arth	Balt	imor	ce, Md	. 212	236		
	20a. METHOO OF DISPOSITION 1 (XBurlai 2 Cremetion 3 Removal from State 4 Donation 6 Other (Specify) St. Charles Borromeo Cem. 12/18/95 Pikesville, Md.												
	21. SIGNATURE OF PUMERAL SERVICE LICEN	DEE (· Onar	22.	NAME AN	D AOORES	S OF FACIL	LITY				co, mar	
	The Die	All.							al Hom son, M				
NO	Approximate interval adjects, or complications that caused the death. Do not antar the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, Due To (OR AS A CONSEQUENCE OF):												
CERTIFICATION	If sny, laeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST												
PHYSICIAN: MEDICAL	PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part					art 1.	24a, WAS AN PERFOR 1 YES 2	MED?		WERE AUTOPSY FIN AWAILABLE PRIOR TO COMPLETION OF CA DF DEATH? 1 X YES 2 NO	USE		
z	DID TOBACCO USE CONTRIB	BUTE TO CAUSE OF	DEATH Y	ES 🔲 I	NO [UNCE	RTAIN						
CA	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	QSPITAL:	S. PLACE OF DE		. , ,								
1SI	V 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Ainpetiant 2 ER/Outp	itlent 3 🗆 DOA	OTHE!		5 🗆 Resi	idence 8	☐ Other	(Specify)				
H	27. MANNER OF DEATH	28e. DATE OF INJURY (Month, Day, Year)	28b. TI	ME OF	28c. INJI	JRY AT	2	28d. DE\$(CRIBE HOW IF	YJURY OCC	CURED		
ВУ	1 Natural 5 Pending 2 Accident Investigation			м		ES 2 🗌	NO						
	3 Suicide 8 Could not be 4 Homicide determined	28e. PLACE OF INJURY building, etc. (Speci	At home, ferm,	street, feci	tory, office)	2		TION (Street e or Town, State)	and Number	or Rural Ro	oute Number,	
COMPLETED	29e. CERTIFIER (Check only one) CERTIFYING PHYSICIAL (Check only one)												
Ö	2 MEDICAL EXAMINER: C	On the beele of examination	end/or investigat	lon, in my c	pinion, de	ath occure	d at the tim	me, date	end place, en	d due to th	e Ceuse(e)	end manner ee sta	ted.
BE C	29b. SIGNATURE AND TITLE OF CERTIFIER			_		29c. LICEN	SE NUMBE	ER		29d. DATI	E SIGNED	(Month, Day, Year)	
	no me		- M			D4300	03			> /	2-1	5-95	-
5	Nathan A. Dunsmore	M.D. 6701	TH (ITEM 27) (Typ	e, Print) GY	reate			ore	Medica	1.00	nter		
	31. DATE FILED (Month.: Day. Year)	M.U. D/UI	N. Cha	ries	Stre	et,	Balti	Imor	e, MD	212	04		
	31. DATE FILED (Month) Day 1995 July	divolentes	64										

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SPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 ma	VERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, print 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burfal, cremation, or removal.
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N 11	LUCY 4. SOCIAL SECURITY NUMBER 215-03-5367 90. FACILITY NAME (If not institution, gh Saint Joseph Med RESIDENCE OF DECEDENT 100. STATE 100. COU Maryland 100. STREET AND NUMBER 903 Old Falls 11. MARITAL STATUS 1 Nover Married 2 Merried 3 X Widowed 4 Diverced	1 □ M 2 X F 8 The street and number) dical Center NTY Harford 12. WAS DECEDENT EVER 1 FORCES? 1 □ YES	(In yrs. last birthday) YRS.		M HRS. 7. DATE (Month APR) N OF OEATH	of DEATH 100 15 15 15 15 15 15 15 15 15 15 15 15 15	8. Bill Co.	7:35 pm RTHPLACE (State or Foreign tripy) rth Carolir F DEATH	
ED BY FUNERAL	215-03-5367 Saint Joseph Med RESIDENCE OF DECEDENT 100. STATE 100. COU Maryland 100. STREET AND NUMBER 903 01d Falls 11. MARITAL STATUS 1 Never Married 2 Merried	a treet and number) dical Center NTY Harford 12. WAS DECEDENT EVER 1 FORCES? 1 □ YES	35 YRS.	9b. CITY, TOWN OR LOCATION Y, TOWN OR LOCATION Fa	N OF OEATH	n, Day, Year)	910 Not	rth Carolir	
ED BY FUNERAL	Saint Joseph Med RESIDENCE OF DECEDENT 10e. STATE 10b. COU Maryland 10e. STREET AND NUMBER 903 01d Falls 11. MARITAL STATUS 1 Never Married 2 Merried	Harford ton Road 12. WAS DECEDENT EVER I FORCES? 1 VES	10c. CIT	Towson, No., town on Location	N OF OEATH		9c. COUNTY O	F DEATH	
ED BY FUNERAL	Maryland 10e. STREET AND NUMBER 903 01d Falls 11. MARITAL STATUS 1 Never Married 2 Merried	Harford ton Road 12. WAS DECEDENT EVER 1 FORCES? 1 YES	10c, CIT	Fa	11-4				
ED BY FUNERAL	10e, STREET AND NUMBER 903 01d Falls 11. MARITAL STATUS 1 Never Married 2 Merried	ton Road 12. WAS DECEDENT EVER FORCES? 1 VES		Fa	11-4			Table management	
ED BY	903 01d Fa11s 11. MARITAL STATUS 1 Never Married 2 Merried	12. WAS DECEDENT EVER			11ston			10d. INSIDE CITY LIMITS? 1 YES 2X NO	
ED BY	11. MARITAL STATUS 1 Never Married 2 Merried	12. WAS DECEDENT EVER		10f. ZIP CODE	21047			SA	
TED		IF YES, GIVE WAR OR D	2 NO	13. WAS DECENDENT OF	HISPANIC ORIGIN Mexicen, Puerto I	? (Specify Yes Ricen, etc.)	or No- 14. R	ACE — American Indien, lack, White, etc. pec/ly:	
	15. DECEDENT'S E (Specify only highest gn Elementary/Secondary (0-12)	College (1-4 or 5+)	(Give kind of v		((Civili	iness/industry	White ployee)	
COMPL	17. FATHER'S NAME (First, Middle, Lest)	4	Clerk/S	tenographer	ER'S NAME (First, A	Navy			
#	Roby Ki 19a. INFORMANT'S NAME (Type/Print)	1by	105 11411 1010	4000000 (0)	Eva	Osbo			
임	Joseph Peters	, Sr.		ADDRESS (Street and Number Park Beach					
	20a. METHOD OF DISPOSITION 1 Burlal 2 Cremetion 3 Re	201	b. PLACE AND DATE O	DE DISPOSITION (Name of	DATE	200 100	CATION — City or		
	4 Donation 5 Other (Specify) 21. SIGNATURE OF JUNERAL SERVICE	N	letro Cre	matory, Inc.	12/17/9	5 Ba	altimo	re, MD	
,				Cremation	n Socie	ty of	Md.,		
	George E. MacNabb 299 Frederick Rd. Balto., MD 212 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approxima								
	shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) CARDIAC HEMORRHAGE								
	DUE TO (OR AS A CONSEQUENCE OF): EMERGENGY CORONARY ARTERY BYPASS								
ATIO	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING b. DUE TO (OR AS A CONSEQUENCE OF): CARDIAC CATHETERIZATION							Hours	
CERTIFICATION	CAUSE (Disease or Injury that initiated events resulting in death) LAST	DUE TO (OR AS	A CONSEQUENCE OF	CONSCOUENCE OF): CORONARY ARTERY					
AL C	PART II. Other algnificant conditi	iona contributing to death t	but not resulting I	n the underlying cause gi	ven in Part I.	24e. WAS AN		146. WERE AUTOPSY FINDI	
MEDIC	CORONARY ART					PERFOR		AVAILABLE PRIOR TO COMPLETION OF CAU OF DEATH? 1 VES 2 NO	
PHYSICIAN:	DID TOBACCO USE CON 25. WAS CASE REFERRED TO MEDICAL	TRIBUTE TO CAUSE C	26. PLACE OF DEAT		RTAIN 🗆				
SIC	EXAMINER?	HOSPITAL:		OTHER: 4 □ Nursing Home 5 □ Red	Idence 8 🗆 Other	(Specify)			
PH PH	27. MANNER OF DEATH 1 Natural 5 Pending Investigatio	28s. DATE OF INJURY (Month, Day, Year)	28b. TIMI	E OF 28c. INJURY AT	28d. DE\$		JURY OCCURED		
3	3 Suicide 6 Could not be determined	28e. PLACE OF INJURY	Y — At home, ferm, a	street, factory, office		ATION (Street or or Town, Stete)	nd Number or Run	al Route Number,	
COMPLET		YSICIAN: To the best of my know						e(e) end menner as state	
	29d SHONATURE AND THE OF CENTIF	hald Che	ef Candine	Surgery D 2	SE NUMBER			EO (Month, Day, Year)	
-	GARTH MCDONAL			D TOWSON, M	ARYI AND	21204			
1	31. DATE FILED (Month, Doy, Year)	32. REGISTRAR'S SIGN		2 . 5415514, 101	3 1167 4 467				



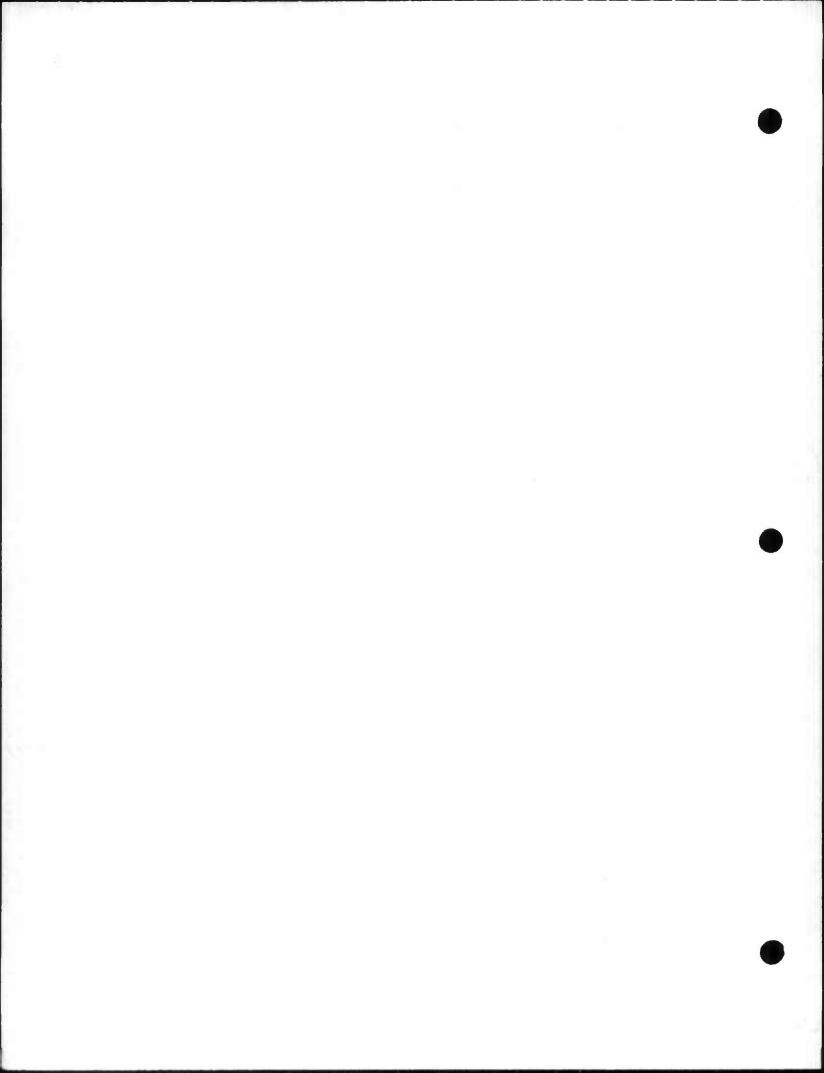
BALTIMORE, MARYLAND 21215-0020	nay be retained by the hospital or attending physici
BALTIMO	hours after death. Page 6
DIVISION OF VITAL RECORDS, P.O. BOX 68760	L OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending t
DIVISION OF VITAL	L OR ATTENDING PHYSICIAN: The law

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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STATE OF MARYLAND	/ DEPARTMENT	OF HEALTH A	ND MENTAL	HYGIENE
	CERTIFICATE	OF DEATH	4	DEC NO

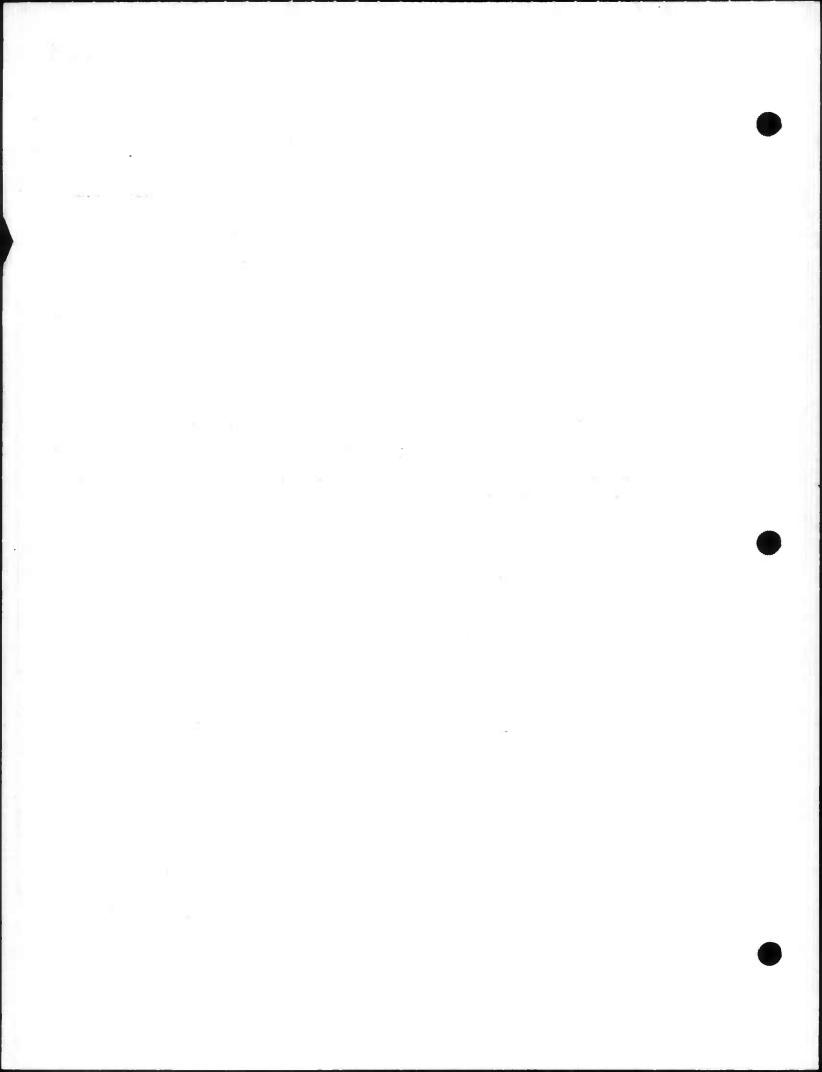
	1 - STATE REGISTRAR	STATE OF MARYL	AND / DEPARTI			MENT	AL HYGIENE	E		
	1. DECEDENT'S NAME (First, Middle, Lest)	Eric Joseph	Sheldon			MOR	E OF DEATH		AR I	6:05 AM M
	4. SOCIAL SECURITY NUMBER			F UNDER 1 YEAR	IF UNDER 24 HRS.	7. DAT	E OF BIRTH	-/5 -/7 8. E	ZS I	LACE (State or Foreign
	220-90-4381	1 X M 2 □ F 28	3 YAS.	ONTHS DAYS	HOURS MIN.	Tun	e 22, 19		(vranuos	
	9a. FACILITY NAME (If not Institution, give st			b. CITY, TOWN	OR LOCATION OF D		C 22, 1	9c. COUNTY		
E C	Joseph Richey Hos	pice		Baltim	ore City	7		N/A		
5	RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY									
DIRECTOR	Maryland N/A		10c. CITY, 1	TOWN OR LOCA						0d. INSIDE CITY LIMITS?
	10e. STREET AND NUMBER			140	Baltimo	ore (City			YES 2 NO
FUNERAL	1000 N. Gilmore S	troot		1.00	THE PERSON	7				AT COUNTRY?
Š	11. MARITAL STATUS	12. WAS DECEDENT EVER IN	U.S. ARMED	13. WAS DEC	2121 ENDENT OF HISPA		IN? (Specify Yes	US		- American Indian.
	1 Never Merried 2 Merried	FORCES? 1 YES	2 NO	If yes, sp	ecify Cuben, Mexico	en, Puert	o Rican, etc.)	(White, etc.
ВУ	3 Widowed 4 Divorced				-Z-	y.			зрисну.	White
COMPLETED	15. DECEDENT'S EDUC (Specify only highest grade	CATION completed)	16a. DECEDENT'S US	k done during me	ON st of working	- 11	56. KIND OF BUSI	INESS/INDUST	RY	
Ä	Elementary/Secondary (0-12)	College (1-4 or 5+)	Witchen I		10000			7		
ž	17. FATHER'S NAME (First, Middle, Last)		Kitchen H	ьтр			ast Foo			
	Harold C. Sl	heldon					, Middle, Melden S raine Ci			
BE	19e. INFORMANT'S NAME (Type/Print)		19h MAII ING AC	Marie 22300	nd Number or Rural				(-)	
2	Lorraine Sheldon		6644 Wh	itemore	Ct. A	pt.	130 Gle	n Burn	ie.	MD 21061
	20n. METHOD OF DISPOSITION	20b	PLACE AND DATE OF 1	DISPOSITION (No	me of	0/	TE 20c. LOC	ATION - City	or Town	. State
	1 Buriet 2 Cremation 3 Ramo 4 Donation 6 Other (Specify)	Ival from State	tro-crema	tory,	Inc. 12/1	8/95	Bal	timore	. M	D
	21. SIGNATURE OF EUNERAL SERVICE LIC	EUSEE Ma The	'	22. NAME A	DADDRESS OF FA	ACILITY	of Mor	bealtr	T.,,	
	George E. MacN	labb		299 F	rederick	Rd.	Raltim	ore M	D 2	1228
	23. PART I. Enter the diseeses, or c	omplications that caused	the death. Do not	enter the mo	de of dying, auc	ch aa ca	rdiac or reapin	atory arrest,		Approximete
ļ	IMMEDIATE CAUSE (Final	Liet only one cause on ea	ich line.							Interval Between Onset and Death
	disease or condition resulting in death)	ACUTE R	ESPIRAT	012Y	FAILUX	OE				
		DUE TO (OR AS A CONSEQUENCE OF):								
NO	Sequentially list conditions,	ViA-							2 WEEKS	
AT	If any, leading to immediate cause. Enter UNDERLYING	OUE TO (OR AS A DUE TO (OR AS A	CONSEQUENCE OF):	0.000	c= (AI	(25)		,	1 4 = 1.05
윤	CAUSE (Disease or Injury that initiated events	DUE TO (OR AS A	CONSEQUENCE OF):	DISEM	SEC	/1/	00) (WITI-	1	LYCHIC
CERTIFICATION	resulting in death) LAST	Aio.	S DEM	ENTI	4					
Ö	PART II. Other algnificent conditions					D I		T		
CAL	Tail II. Other mightheonic conditions	s contributing to deeth by	at not resulting in t	ne undenyin	g ceuse given in	Part I.	24s. WAS AN A PERFORM	AED?	A	VAILABLE PRIOR TO
							1 TES 2)	NO NO		OMPLETION OF CAUSE F DEATH?
Σ	DID TOBACCO USE CONTR	DIRLITE TO CALISE O	E DEATH VEC	ПМОГ	UNCERTAI	NI D		- 1	1	YES 2 NO
PHYSICIAN: MEDIC	25. WAS CASE REFERRED TO MEDICAL		26. PLACE OF DEATH		UNCERIAL	ΝЦ				
Sic	EXAMINER?	HOSPITAL: 1 Inpatient 2 ER/Output		THER:	e 5 🗆 Residence	6 X OH	ner (Specify)	Jos Nico	= /	JOS RICHE
¥	27. MANNER OF DEATH	26e. DATE OF INJURY	28b, TIME O	F 28c. INJ	URY AT	/	ESCRIBE HOW IN.			VOUNCAE
ВУ	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	INJUR		RK7 'ES 2 NO					
ED E	3 Suicide 6 Could not be	28e. PLACE OF INJURY building, atc. (Speci	— At home, lerm, stre-	et, lectory, offic		261, LO	CATION (Street en	d Number or Ru	ural Rou	te Number,
3	4 Homicide determined		<u> </u>				y ar rown, dialoy			
COMPLET	29e. CERTIFIER (Check only	CIAN: To the best of my knowle	edge, death occurred a	It line time, date	end place, and due	to the c	euse(e) end mann	er ee atated.		
Š	2 MEDICAL EXAMINER	R: On the basis of examination	end/or investigation, i	n my opinion, d	eath occured at the	time, de	te and place, and	due to the cau	180(0) 8	nd manner se stated.
BE C	296. SIGNATURE AND TITLE OF CERTIFIER	7			29c. LICENSE NUI	MBER		29d. DATE SIG	NEO (M	fonth, Day, Year)
9		empleled of	MI		2009	61		12-	17.	- 95
-	30. NAME AND ADDRESS OF PERSON WHO									
	Edward W. Campbel	1, Jr., M.D.	419 W. R	edwood	St. Bal	timo	re, MD	21201		
	DEC1 9 1995	32 REGISTRAR'S SIGNA	Rardall							



BALTIMORE, MARYLAND 21215-0020	A hours after death. Page 6 may be retained by the hospital or attending physician.	filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page on or removal.
DIVISION OF VITAL RECORDS, P.O. BOX 68760	TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within-rs hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

	FOR 1 STATE	STATE OF MARYLAND) / DEPAF	RTMENT OF H	lealth and	MENTAL HYGIEN	F	00230
	REGISTRAR		CERTIF	ICATE OF	DEATH	REG. NO		3. TIME OF DEATH
	1. DECEDENT'S NAME (First, Middle, Lust) Samuel Salvatore Spedalere					DECEMBE	13,1	1991 1235 PM
		-	6. AGE (In yrs. last birthday) F UNDER 1 YEAR F UNDER 24 HRS.			7. DATE OF BIRTH (Month, Day, Year)		BIRTHPLACE (State or Foreign Country)
	9a. FACILITY NAME (If not institution, give stre	10	1113.	9b. CITY, TOWN	OR LOCATION OF I			Maryland
DIRECTOR	Carroll County General Hospital			We	stmins	ter	1	arroll
RC	10e. STATE 10b. COUNTY		10c. CIT	Y, TOWN OR LOCAT	TION			10d. INSIDE CITY
	Maryland Ba	ltimore				e Hall		1 YES 2 N NO
FUNERAL	1015 Wiseburg R	load		101	. ZIP CODE	161	10g. CITIZ	EN OF WHAT COUNTRY?
I S	11. MARITAL STATUS	12. WAS DECEDENT EVER IN U.S. FORCES? 1 X YES 2	ARMED	13. WAS DEC	ENDENT OF NISP	ANIC ORIGIN? (Specify Yes	or No-	USA 14. BACE — American Indian,
BY F	1 Never Married 2 Married 3 Widowed 4 Divorced	IF YES, GIVE WAR OR DATES			2 X NO Spec	ean, Puerto Rican, atc.)		Black, White, stc. Specify:
	15. DECEDENT'S EDUCA (Specify only highest grade co	TION 16a.	DECEDENT'S	USUAL OCCUPATION	DN	16b. KIND OF BU	SINESS/INDU	White
once. COMPLETED	Elementary/Secondary (0-12)	College (1-4 or 5+)		work done during mo se retired.)	ist of working	2.51 91-5 72.71		
DAMP	10	B	rick	Mason	10 MOTHER'S M	Con		ction
ш	Frank Spe	dalere			is. mother 3 is	Carmella		rro
TO B	19a. INFORMANT'S NAME (Type/Print)					Route Number, City or Tow	n, State, Zip (Code)
2 2	Lois R. Corts			Wisebu				MD 21161
aust aust	20b. METHOD of DISPOSITION 1 Burfal 2 X Cremation 3 Removal from State 4 Donation 6 Other (Specify) Metro Crematory, Inc. 12/16/95 Baltimore, MD							
niner	21. SIGNATURE OF FUNERAL SERVICE LICEN	1SEEN MILL	-	22. NAME AI	ND ADDRESS OF F	ACILITY		
	George E. MacNabb Cremation Society of Md., Inc. 299 Frederick Rd. Balto. MD 21228							
nt, the medical	23. PART I. Entar the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart fellure. Liet only one cause on each line. IMMEDIATE CAUSE (Finel Onset and Dasth							at, Approximate interval Between Onset and Death
ury, or other traumatic event, CERTIFICATION	disease or condition resulting in death) Due to (or as a consequence of): Due to (or as a consequence of): Out of the conditiona, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated eventa resulting in death) LAST Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):							
snows any injuit. : MEDICAL	PART II. Other aignificent conditions contributing to deeth but not resulting in the underlying ceuse given in Part I. 24a. WAS AN AUTOPSY FINDINGS AMR.ABLE PRIOR TO COMPLETION OF CAUSE OF GEATH?							OF OEATH?
	DID TOBACCO USE CONTRI	BUTE TO CAUSE OF D	EATH YE	S NO C	UNCERTA	IN/CI		1 TYES 2 NO
PHYSICIAN:		HOSPITAL:		(Check only one) OTHER:				
HYS	1 YES 2 NO 1	28a. DATE OF INJURY	3 DOA 28b. TIM			6 Other (Specify)	MILIEN OCCI	IREO
BY PH	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	INI	M 1 1	RK?			
	3 Suicide 6 Could not be determined	28s. PLACE OF INJURY — Al building, etc. (Specify)	home, farm,	street, lactory, office	1	26f. LOCATION (Street a City or Town, State)	and Number of	r Rural Route Number,
COMPLET		AN: To the best of my knowledge, On the basis of examination and						
TO BE COM	296 SHANATURE AND TITLE OF CERTIFIER OAN H, S Chur	Ufder w	9		29 LICENSE NU	ZZ(29d. DATE :	SIGNED (MONTH, Day, Year) CLABRE 13,1991 CMANYLAND
	DAN H. SCHNEIBI	FORM MY	200M	EMONIA	c Aven	NE WESTA	NSTE	e marriano
	DEC1 9 1995	32. REGISTRAR'S SIGNATUR						21157

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	O THE FUNERAL, DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit.		
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ENDIG	OR: Af	fter de	8 S
AL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or atten	DIRECT	ours a	lem 2
JITAL !	RAL	127 h	ENN
HOSE	FUNE	within	TANT
O THE	O THE	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or n	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notifi
-	1	9	-

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. 1 DECEDENT'S NAME (First Middle Last) 2. DATE OF DEATH 3. TIME OF DEATH 15 DEC. 1995 4:18 P. SANDERS ZINA ROSE 4. SOCIAL SECURITY NUMBER 5. SEX 7. DATE OF BIRTH
(Month, Day, Yeer)
FEB. 1, 1972 6. AGE (in vrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign DAYS HOURS 1 M 2 F MARYLAND 216-74-1409 23 9e. FACILITY NAME (If not institution, give street end number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR N/A 3911 LABYRINTH RD. BALTIMORE RESIDENCE OF DECEDENT 10e. STATE 10c. CITY, TOWN OR LOCATION BALTIMORE 10d. INSIDE CITY MARYLAND N/A 1 XYES 2 NO 10e. STREET AND NUMBER FUNERAL 101. ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? 21215 USA 3911 LABYRINTH RD. 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—I1 yee, specify Cuben, Maxican, Puerto Ricen, etc.)
1 YES 2 N NO Specify: 12. WAS DECEDENT EVER IN U.S. ARMED 14. RACE — American Indian Black, White, atc. FORCES? 1 YES 2 1 Never Married 2 Merried Specify WHITE BY 3 Widowed 4 Divorced ETED. 15. DECEDENT'S EDUCATION 18e. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade com ast of working (Give kind of work done life. Do NOT use retired.) College (1-4 or 5+) Elementary/Secondary (0-12) COMPL 5+ AUDIOLOGIST HEARING IMPAIRED 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Meiden Surname) Larry Sanders Frances Last BE 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Mr. Larry Sanders 3911 Labyrinth Rd, Baltimore, MD 21215 20s. METHOD OF DISPOSITION

XXBurlel 2 Cremetion 3

4 Donation 1 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State DATE 3 | Removal from State Agudath Israel 12/17/95 Baltimore, MD 22. NAME AND ADDRESS OF FACILITY SOL LEVINSON & BROS., INC. May 6010 REISTERTOWN RD. BALTO., MD 21215 ruger PART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or reapiratory arrest, ahock, or heart fellure. Use only one cause on each line. Interval Between Onset and Death **IMMEDIATE CAUSE (Final** disease or condition Primitive Neuroectodermal Tumor 9 years resulting in death) Pneumonia 2 weeks CERTIFICATION Sequentielly list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): thet initieted events resulting in death) LAST PART II. Other aignificent conditions contributing to deeth but not resulting in the underlying ceuse given in Part I. 24s. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS MEDICAL AVAILABLE PRIOR TO COMPLETION OF CAUSE 1 YES 2 NO 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO W UNCERTAIN PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL 1 YES 2 NO Inpatient 2 - ER/Outpatient 3 - DOA 4 Nursing Home 5 Residence 8 Other (Specify) 28a. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 27. MANNER OF DEATH 28d. DESCRIBE HOW INJURY OCCURED 1 Natural 5 Pending Investigation 1 YES 2 NO ВУ 2 Accident 28e. PLACE OF INJURY — At home, farm, street, fectory, office building, atc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 8 Could not be determined COMPLETED 4 Homicide 29e. CERTIFIER (Check only 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data end place, and due to the cause(e) end manner as stated. 2 MEDICAL EXAMINER: On the basis of exemination end/or investigation, in my opinion, death occured at the time, date end place, end due to the cause(a) and manner as stated. 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE (alla. 041444 ► December 16, 1995 2 OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) Type, Print)

Johns Hopkins Hospital

KENNETH COHEN

DEC1 91995

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aw requires that the death cert	s been signed by the attending	ept. of Health and Mental Hygie	23 shows any injury, or oth
The law requires that the death cert	e has been signed by the attending	te Dept. of Health and Mental Hygie	m 23 shows any injury, or oth
AN: The law requires that the death cert	ficate has been signed by the attending	State Dept. of Health and Mental Hygie	r Item 23 shows any injury, or off
SICIAN: The law requires that the death cert	certificate has been signed by the attending	the State Dept. of Health and Mental Hygie	I, or Item 23 shows any injury, or off
PHYSICIAN: The law requires that the death cert	this certificate has been signed by the attending	with the State Dept. of Health and Mental Hygie	rked, or Item 23 shows any injury, or off
NG PHYSICIAN: The law requires that the death cert	ifter this certificate has been signed by the attending	eath with the State Dept. of Heatth and Mental Hygie	marked, or Item 23 shows any injury, or off
ENDING PHYSICIAN: The law requires that the death cert	IR: After this certificate has been signed by the attending	ter death with the State Dept. of Health and Mental Hygie	is marked, or item 23 shows any injury, or off
ATTENDING PHYSICIAN: The law requires that the death cert	ECTOR: After this certificate has been signed by the attending	s after death with the State Dept. of Health and Mental Hygie	n 28 is marked, or Item 23 shows any Injury, or off
DR ATTENDING PHYSICIAN: The law requires that the death cert	DIRECTOR: After this certificate has been signed by the attending	hours after death with the State Dept. of Health and Mental Hygie	item 28 is marked, or Item 23 shows any injury, or off
ITAL DR ATTENDING PHYSICIAN: The law requires that the death cert	RAL DIRECTOR: After this certificate has been signed by the attending	72 hours after death with the State Dept. of Health and Mental Hygie	If item 28 is marked, or Item 23 shows any injury, or off
OSPITAL DR ATTENDING PHYSICIAN: The law requires that the death cert	UNERAL DIRECTOR: After this certificate has been signed by the attending	rithin 72 hours after death with the State Dept. of Health and Mental Hygie	ANT: If item 28 is marked, or Item 23 shows any Injury, or off
1E HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death cert	4E FUNERAL DIRECTOR: After this certificate has been signed by the attending	ed within 72 hours after death with the State Dept. of Health and Mental Hygie	DRTANT: If item 28 is marked, or Item 23 shows any injury, or off
TO THE HOSPITAL DR ATTENDING PHYSICIAN: The faw requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hosp	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detache	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

	1 - FOR STATE REGISTRAR	E OF MARYLAND	DEPARTMERTIFIC			MENTAL HYGIEN	_		
	1. DECEDENT'S NAME (First, Middle, Last) $STEVEN$	2. DATE OF DEATH DON'TH DECEMBENC	MONTH DAY YEAR						
	4. SOCIAL SECURITY NUMBER 5. SEX	6. AGE (In yrs. Ia		UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)	8. Bif	RTHPLACE (State or Foreign	
	219-58-5398 1 🗓 M 9a. FACILITY NAME (If not institution, give street and no	- युक्	YRS.	CITY, TOWN O	R LOCATION OF D		Maryland		
TOR	University Hospital			Balt	imore		N	/A	
DIRECTOR	10a. STATE 10b. COUNTY Maryland Baltimon	re		ings M				10d. INSIDE CITY LIMITS? 1 YES 2 NO	
	10e. STREET AND NUMBER				ZIP CODE		10g. CITIZEN O	F WHAT COUNTRY?	
FUNERAL	131 Mabin Circle				21117		U.S.	λ	
	11. MARITAL STATUS 12. WAS	DECEDENT EVER IN U.S. A			ENDENT OF HISPA	NIC ORIGIN? (Specify Ye	a or No- 14. R	ACE — American Indian,	
ВУ F	1 Never Merried 2 Narried IF YE 3 Widowed 4 Divorced	CES? 1 TYES 2 THE SES, GIVE WAR OR DATES	No.	tf yes, spe 1 ☐ YES		an, Puerto Rican, atc.)	100	neck, white, etc. pecify: White	
COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed)) (0	ECEDENT'S USU	done during mo:		16b, KIND OF BU	SINESS/INDUSTR		
Ë	Elementary/Secondary (0-12) College	(1-4 or 5+)	e. Do NOT use rei						
ME	17. FATHER'S NAME (First, Middle, Last)	Se	elf Emp	loyed			nandisin	<u>a</u>	
	Douglas	Scher	_		Rit	AME (First, Middle, Maiden	Veri	on	
BE	19a, INFORMANT'S NAME (Type/Print)			DESS (Street a		Route Number, City or Tov			
2	Mrs Janice Scherr					Owings Mi			
	20a. METHOD OF DISPOSITION XX Burlel 2 Cremetion 3 Removal from	20b. PLACE	AND DATE OF D	SPOSITION (Na	me of	DATE 20c. LC	CATION — City or	Town, State	
	4 🗆 Donetion 5 🗆 Other (Specify)	Balt	ematory or other Imore H				Baltimor	e, MD	
	21. SIGNATURE OF FUNERAL SERVICE HOMESE			S		son & Bros			
	23. PART I. Enter the diseases, or stimplics	tions that caused the d	leeth Do not					e, MD 21215	
	ahock, or haart fallum. List only	One cause on each line	a.			or an order or resp	matory arreat,	Interval Batween Onset and Dasth	
TION	Sequentielly list conditions, if any, leading to immediate	DUE TO (OR AS A CONSE	TAC /			6			
CERTIFICATION	cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated avents resulting in death) LAST	DUE TO (OR AS A CONSI	EOUENCE OF):						
	PART II. Other aignificant conditions contril	outing to death but not	rasulting in t	ha undarivino	cause given in	Part I. 24s. WAS A	ALITOPSY	24b. WERE AUTOPSY FINDINGS	
EDICAL							RMED?	AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?	
2	DID TOBACCO USE CONTRIBUTE	TO CALISE OF DE	ATLL VEC		UNCERTAI	N. C.		t - YES 2 DE NO	
AN	25. WAS CASE REFERRED TO MEDICAL		CE OF DEATH		UNCERIA				
Sici	EXAMINER? HOSP	tTAL:		THER:	s 5 D Booldones	6 Other (Specify)			
PHYSICIAN:	1	DATE OF INJURY (Month, Day, Year)	28b. TIME O	28c. tNJ WO	URY AT	28d. DESCRIBE HOW	INJURY OCCURED		
D BY	2 Accident Investigation	PLACE OF INJURY — At h building, etc. (Specify)	nome, ferm, stree	M 1 1		28f. LOCATION (Street City or Town, State		rel Route Number,	
ш	4 Homicide determined								
COMPLET	29e. CERTIFIER (Check only one) 1 A CERTIFYING PHYSICIAN: To 1 December 2 MEDICAL EXAMINER: On the							se(a) end menner as stated.	
BE	296 OFFICE AND TITES OF CENTIFIER)mo			29c. LICENSE NU	MBER O	1	MED (Month, Day, Year) MAUR 16,1495	
5,	30. NAME AND ADDRESS OF PERSON WHO COMPLETED STORY	ETED CAUSE OF DEATH (IT	EM 27) (Type, Pri	2120), Î	DAVID	HARTE	er Mo.	
5		REGISTRAR'S SIGNATURE							

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PHYSICIAN: MEDICAL CERTIFICATION

BE COMPLETED BY

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	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within Z4 hours	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in b	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or rer	IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medi
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•	FOR STATE REGISTRAR	STATE OF MARY		MENT OF H		MENTAL HYGIEN REG. NO.	E	Language .
	1. DECEDENT'S NAME (First, Middle, Landon AVI)	" SIEG	EL			2. DATE OF DEATH DA DECEMB		YEAR 3. TIME OF DEATH
	4. SOCIAL SECURITY NUMBER 218 - 42 - 538		(In yrs. last birthday) Royals YRS.	F UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	July 3	-	BIRTHPLACE (State or Foreign Country) MARYLAND
	SO. FACILITY NAME (If not institution, ghas for three Theorem Horse of December 1	ospital Cente		Baltin	nore C	ounty	Bal	timore
	10e, STATE 10b. COU	BALTIMORE		attimo				10d. INSIDE CITY LIMITS? 1 YES 2 YNO
	217 Slade	avenue		101.	21204	3	tog. CITIZE	A
	11. MARITAL STATUS 1 Never Merried 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER FORCES? 1 XYES IF YES, OIVE WAR OR	3 2 NO	If yes, spi		HC ORIGIN? (Specify Yea n, Puerto Rican, atc.)	or No— t	4. RACE — American Indian, Black, White, atc.
	15. DECEDENT'S E (Specify only highest gr Elementary/Secondary (0-12)		ille. Do NOT use	ork done during mo: e retired.)		16b. KIND OF BUS		
	17. FATHER'S NAME (First, Middle, Last) HARRY	S	LEGEL BROKE	·iR	18. MOTHER'S NA ANN	ME (First, Middle, Meiden		instein
	199. INFORMANT'S NAME (Type/Print) MR. EUGENE SIEC	GEL		AOORESS (Street s		Route Number, City or Tow ILVER SPRI		
	20e. METHOD OF DISPOSITION P Buriel 2 Cremation 3 F 4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE	smoval from State	bb. PLACE AND DATE Of the second seco	her place) B ANSHE	VESHEAR	0ATE 20c. LO 12/15/95 CHIT BROS., I	RO	SEDALE, MD
	· Scotti	M. Cuttle				OWN RD. E		, MD 21215
	23. PART I. Enter the diseases, shock, or heart failu IMMEDIATE CAUSE (Final disease or condition resulting in death)	re. List only one cause on	each line.	CAT		the an cardiac or respondence of the second		at, Approximats Interval Between Onset and Daath

PART II. Other algnificent conditions contributing to deeth but not resulting in the underlying cause given in Part i.

DUE TO (OR AS A CONSEQUENCE OF):

DUE TO (OR AS A CONSEQUENCE OF):

24a. WAS AN AUTOPSY PERFORMED? 1 TYES 2 1 NO

281. LOCATION (Street and Number or Rural Route Number, City or Town, State)

24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 TYES 2 NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 🗵 25. WAS CASE REFERRED TO MEDICAL EXAMINER?

28. PLACE OF DEATH (Check only one)							
OTHER: Inpetient 2 ER/Outpetient 3 DOA 4 Nursing Home 5							
28s. DATE OF INJURY (Month, Day, Year)	28b. TIN	E OF JURY	28c. INJUI WOR	K?			

28s. PLACE OF INJURY — At home, ferm, atreet, fectory, office building, stc. (Specify)

Residence 8 - Other (Specify)

28d. DESCRIBE HOW INJURY OCCURED 28c. INJURY AT WORK? 1 YES 2 NO

2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TIT	LE OF CERTUNER	1.0	
	C /	an (1)	

29c. LICENSE NUMBER

29d. DATE SIGNED (MONTH, Day, Year)

▶ DECEMBENIY, 9,1

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

AV,	Mn	NHC,	SALTO	MO	2113:	3
3	REGISTRAR'S	IGNATURE				ī

31 DEC1 M91995

5 Pending Investigation

S Could not be determined

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury

that initiated eventa resulting in death) LAST

1 YES 2' NO

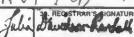
27. MANNER OF DEATH

Natural

Accident

3 Suicids

4 Homicide 29s. CERTIFIER



0.11

29c. License number

OCME

111 Penn Street, Baltimore, Maryland 21201

29d, Date signed (Month, Dev. Year)

DEC.14,1995

State Registrar 29b. Signature and title of certific

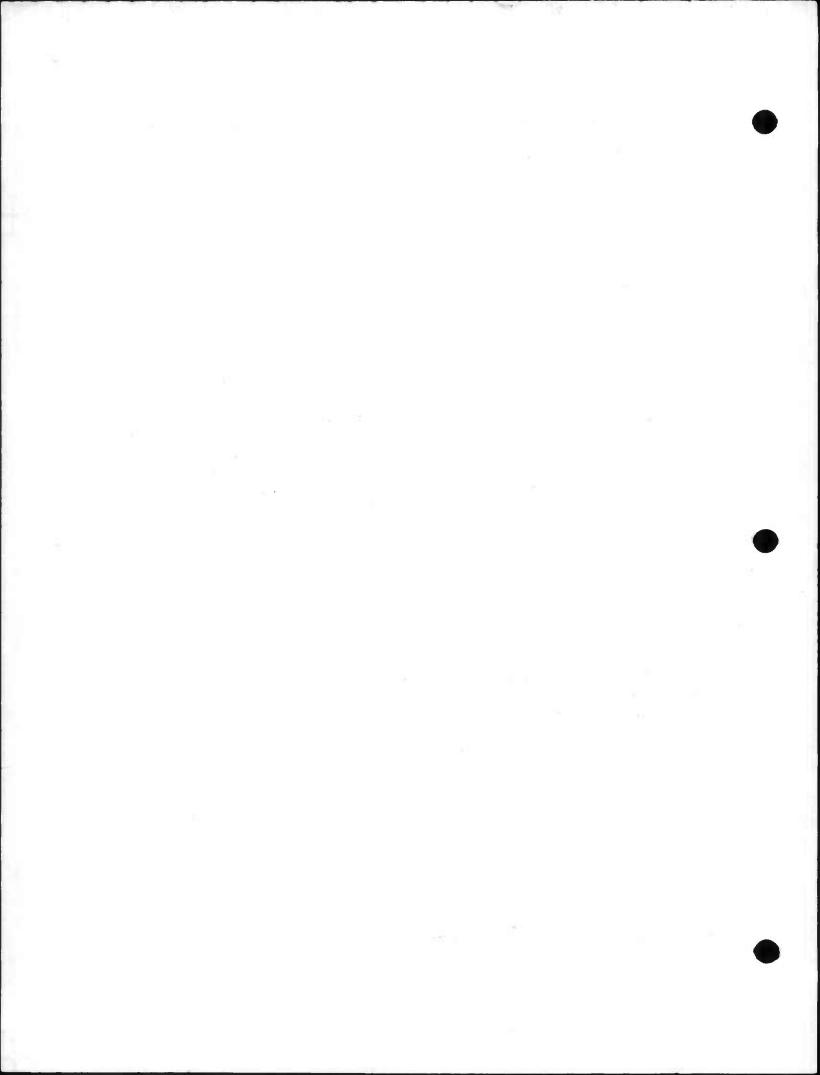
30. Name and address of parson who completed cause of seeth (Itam 23a) (Type, Print) Mikin

Dr. William J

|--|

												95	5 3	8298
	1 - STATE REGISTRAR	STATE	OF MA	RYLAND /		TMENT				MENTAL	HYGIENE REG. NO.			
	t. DECEDENT'S NAME (First, Midd	llo, Last)								2. DATE C				3. TIME OF DEATH
	OZELL EUGEN	NE SMITH								Decer	nber 9		YEAR 995	10:40 A. M
	4. SOCIAL SECURITY NUMBER	5. SEX	6.	AGE (In yrs. last	birthday)	IF UNDER	t YEAR	IF UNDER	24 HRS.	7. DATE O	F BIRTH	,	8. BIRT	HPLACE (State or Foreign
	220-07-4253	1 📉 M 2	F	79	YRS,	MONTHS	DAYS	HOURS	MIN.	(Month,	8, 19	16	SOU	TH CAROLINA
	9a, FACILITY NAME (If not institution	on, give street and numb	or)			9b, CITY	TOWN C	R LOCATE	DN OF DE		, 1		UNTY OF	
E E	ST AGNES HOS	PITAL.						MORE						/A
DIRECTOR	RESIDENCE OF DECEDE												IN	/ A
E E	10a. STATE 10b.	COUNTY			10c. CIT	Y, TOWN	OR LOCAT	ION						10d. INSIDE CITY LIMITS?
	MARYLAND	N/A				BA	LTI	MORE	CIT	Y				1 X YES 2 NO
A P	10e. STREET AND NUMBER						101	ZIP CODI	E			10g. CI	TIZEN OF	WHAT COUNTRY?
FUNERAL	402 MT. HOLL	Y STREET						2:	1229		-		USA.	
S	11, MARITAL STATUS	12. WAS DE	EDENT E	VER IN U.S. ARI	MED	13.	WAS DEC	ENDENT C	F HISPAN	VIC ORIGIN?	(Specify Year			F — American Indian
BY F	1 Never Married 2 K Marrie 3 Widowed 4 Divorced			YES 2 XN	0		If yes, sp		n, Maxica	n, Puerto Ri			Spec	E — American Indian, ck, White, etc. city: ACK
	15. DECEOEN	T'S EDUCATION est grade completed)		16a. DEC	EOENT'S	USUAL O	CCUPATIO	N		16b.	KIND OF BUSI	NESS/IN	IDUSTRY	
COMPLETED	Elementary/Secondary (0-12)	College (1-	or 5 +)	life.	Do NOT u	work done se retired.)	during mo	st of workin	ng					
귤	5th GRADE		,	SK	ILLE	D L	ABOR	ER		FE	RTILIZ	ZER	COM	PANY
ő	17. FATHER'S NAME (First, Middle,	Lest)	-					16. MOTI	HER'S NA	ME (First, Mi	ddle, Maiden S	iurname)		
	LAWRENCE	SMITH						BES	SIE		(MI	N-UN	KNOW	N)
BE	19a. INFORMANT'S NAME (Type/Pri	int)		19b	. MAILING	ADDRESS	(Street a	nd Number	or Rural F	Route Numbe	r, City or Town,	State, Z	in Code)	
2	HERBERT B.	SMITH	SR.											AND 21218
	20a. METHOD OF DISPOSITION			20b. PLACE A	_				, ,	DATE	_			own, State
1 1	1X Burlei 2 ☐ Cremetion 3 4 ☐ Donation 5 Ø Other Spec		te	MT. ZI					1.2	2-15-9				, MARYLAND
	21. SIGNATURE OF FUNERAL SER			III. ZI	.ON C			D ADDRES	_		DA DA	LILI	TOKE	TAKILAND
	·CA	-D	16	m	>	J	OSEE	Н Н.	BRC	OWN JI	R. FUN ST.,	ERAI BAL	L HOI	ME,P.A. RE, MD.21223
	23. PART I, Enter the diseas	es, or complication	a thet c	aused the dec	eth. Do i	not enter	the mo	de of dy	ing, aucl	h as cerdi	ac or respire	etory a	rrest,	Approximate
	IMMEDIATE CAUSE (Final	fellure. List only or	e ceuse	on each line.										Interval Between Onset and Death
	disease or condition	PER	TCOL	IC ABS	OFCC.									10 Days t
	resulting in death)			R AS A CONSED		F):								2 Weeks
7		CHE	ONTO	CACTIV	E II.	EOCO	ודידו	c						
0	Sequentially list conditions, if any, leading to immediate			R AS A CONSED			PILL	3						Weeksto
NA	cause. Enter UNDERLYING	J.												several
ERTIFICATION	CAUSE (Disease or injury that initieted events	D	JE TO (OI	R AS A CONSED	UENCE O	F):								months
듄	resulting in death) LAST													
빙														
A	PART it. Other significent co						deriying	cause (given in	Part i.	24a. WAS AN A PERFORM		24	WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
용	Marked gen		athe	rosclei	cosi	s					Y YES 2			COMPLETION OF CAUSE OF DEATH?
MEDICAL	Nephroscle	rosis									^			X YES 2 □ NO
	DID TOBACCO L	JSE CONTRIE	UTE '	TO CAUS	E OF	DEAT	тн ү	ES 🗀	NO	<u>-</u>				
A	25. WAS CASE REFERRED TO MED							- Long		eck only one)			
SIC	EXAMINER?	HOSPITA 1 A Inpatia	L:	R/Outpatient 3	DOA	OTHER 4 Num		5 □ Pa	sidence	8 Other	(Snecibil)			
PHYSICIAN:	27. MANNER OF DEATH	26a. D/	TE DE IN	JURY	26b. TIM	E OF	28c. INJ	JRY AT			RIBE HOW IN	JURY OC	CCUREO	
	1 Neturel 5 Pendi	ng	nth, Day,	Year)	INJ	URY M	WO	RK7	No I					
B	2 Distant	igation 28a, PL	ACE OF II	NJURY — At hon	ne, farm.	street, fact				28f LOCAT	TION (Street or	of Numbe	er or Rural	Floute Number,
8	4 Homicide determ	THUL DE DU	iding, etc	: (Specffy)						City or	Town, State)	3,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	g. Parist	
COMPLET	290. CERTIFIER	a puwaranci i												
MP	(Check only	G PHYSICIAN: To the												
00	Z MEDICAL E	EAAMINEH: On the bas	e of exam	matton and/or Ir	rvestigatio	on, in my o	pinion, d	ath occur	ed at the	time, data a	nd place, and	due to t	the cause(a) and menner as stated,
w	296. SIGNATURE AND TITLE OF C	ERTIFIER Q	21	a Dr.	0	0		29c. LICE	NSE NUM	ABER		29d. DA	TE SIGNE	(Month, Day, Year)
0 8	- will	X x	Vi	cken	1 4	h D			D049	964		De	cemb	er 11. 1995
2	30. NAME AND ADDRESS OF PER	SON WHD COMPLETE	CAUSE	OF DEATH (ITEM	27) (Type	Print)						20	JUILID	1///

Hicken St. Agnes Hospital 900 Cat



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DIVISION	

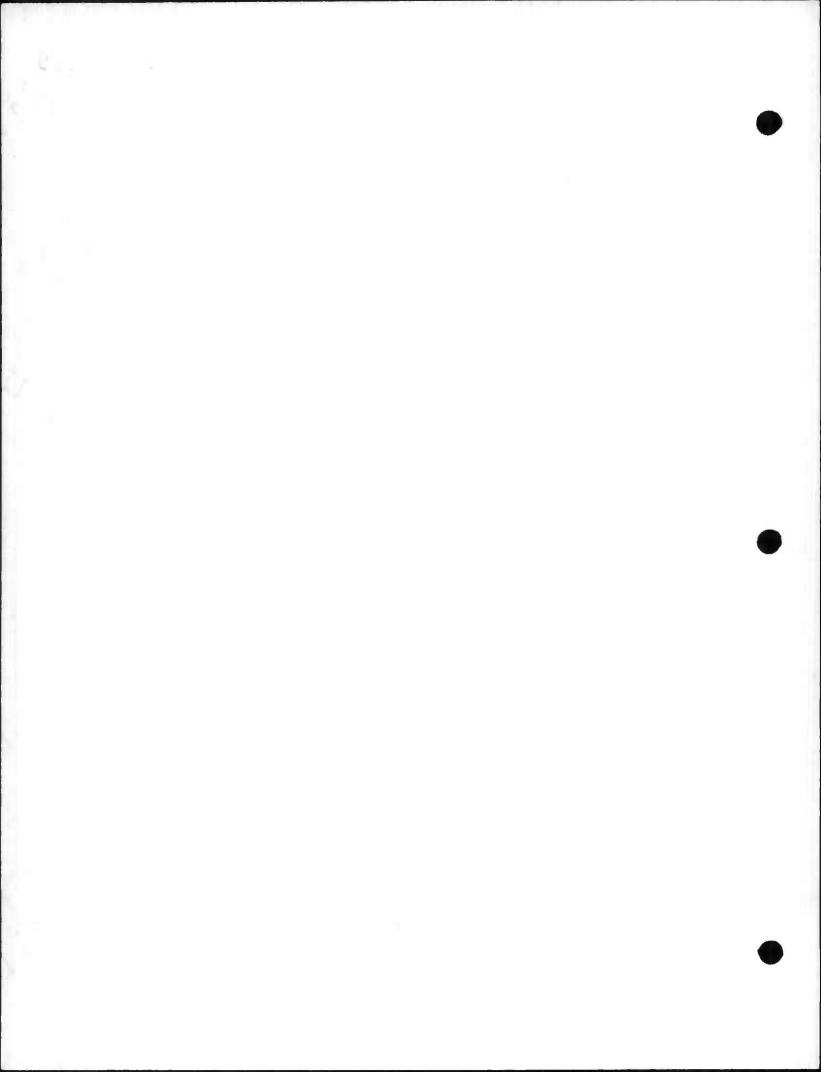
BE 2

30. NAME AND ADDRESS OF PERSON

COMPLETED CAUSE OF DEATH

R REGISTRAR'S SIGNATURE

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH 3. TIME OF DEATN SUSIE SPRIGGS 1995 LEE DEC. 13 7:45 P. M 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (in yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year 8. BIRTNPLACE (State or Foreign 1 M 2X F 84 YRS. 220-18-4295 FEB MISSISSIPPI permit. Pages 1, 2, 3 should 9s. FACILITY NAME (if not institution, give street and number 9b. CITY. TOWN OR LOCATION OF DEATN 9c. COUNTY OF DEATH DIRECTOR 2525 W. PRATT STREET BALTIMORE N/A 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d, INSIDE CITY LIMITS? MARYLAND N/A BALTIMORE 1 X YES 2 NO 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? funeral director, page 5 should be detached for use as the burial-transit 2525 W. PRATT STREET 21223 USA. retained by the hospital or attending physician. 11. MARITAL STATUS 12. WAS DECEDENT EYER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, Whits, etc. 1 Never Married 2 Married If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 TES 2 THO BY Specify: Specify 3 X Widowed 4 Divorced BLACK ETED 16e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use relired.) 15. DECEDENT'S EDUCATION 16h. KIND OF BUSINESS/INDUSTRY (Sp Elementary/Secondary (0-12) College (1-4 or 5+) COMPL 10th GRADE HOMEMAKER OWN HOME 17. FATNER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Sumame) 16 BE MAGGIE GRANGER notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 547 SOUTH PACA STREET, BALTIMORE, MD. 21230 ROBIN THOMPSON death. Page 6 may be 9 20a. METNOD OF DISPOSITION
1 □ Burial 2 □ Cremation 3 □ Ramoval must b 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Yown, State CROWNSVILLE CEMETERY 12-17-95 CROWNSVILLE, MD. 4 Donation 8 Other (Specify) examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22, NAME AND ADDRESS OF FACILITY JOSEPH H. BROWN JR. FUNERAL HOME, P.A. 1913 W. BALTIMORE ST., BALTIMORE, MD.21223 n and completely filled in by the to burial, cremation, or removal. hours after the medical 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart fellure. List only one ceuse on interval Between IMMEDIATE CAUSE (Final Onset and Death disease or condition resulting in death) event, DUE TO (OR AS A CONSEQUENCE OF the death certificate be executed traumatic CERTIFICATION Sequentially list conditions, if any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF) been signed by the attending physician at. of Health and Mental Hygiene prior to cause. Enter UNDERLYING CAUSE (Disesse or injury or other that initiated events DUE TO (OR AS A CONSEQUENCE OF): resulting in death) LAST injury, PART II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part i. MEDICAL 24s. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? Tempon OR ATTENDING PHYSICIAN: The law requires that shows any 1 YES 2 NO 1 YES 2 NO PHYSICIAN: DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES IN NO DA UNCERTAIN 23 TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law TO THE FUNERAL OHECTOR: After this certificate has be filed within 72 hours after death with the State Dept IMPORTANT: If item 28 is marked, or item 23 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one, **EXAMINER?** HOSPITAL 1 | YES 2 NO 1 Inpatient 2 ER/Outpatient 3 I Residence 8 Other (Specify) 4 Nursing Home 5 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT 28d. DESCRIBE HOW INJURY OCCURED 1 Natural Accident М 1 YES 2 NO BY 28s. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 3 Sulcide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 6 Could not be COMPLETED 4 Homicide datermined 29s. CERTIFIER CERTIFYING PHYSICIAN: best of my knowledge, death occurred at the time, data end place, and due to the cause(s) and menner as stated. 2 MEDICAL EXAMINER: Or 29b. SIGNATURE AND



	FOR STATE REGISTRAR	STATE OF MARYL				IEALTH AND N	MENTA	L HYGIENE REG. NO.				
1	t. DECEDENT'S NAME (First, Middle, Last) FRANK	(NMN)		(SALI	NA	MONT	OF DEATH DAY		EAR	6.20	
J	4. SOCIAL SECURITY NUMBER 717-09-0380 98. FACILITY NAME (If not institution, give si	1 🛛 M 2 🗆 F 9	(In yrs. last I	YRS. MON		F UNDER 24 HRS. HOURS MIN. OR LOCATION OF DE	Feb	of BIRTH h. Day, Year) ruary 4	,1904	Ma	rylanc	ore/gn
TOR	Good Samaritan H			1		ore . Ci				N/A		
DIRECTOR	Maryland 10b. country				NOTE,	Marylan	d			1	d. INSIDE CITY LIMITS? YES 2	
NERAL	4110 Mary Ave					21206			U	.S.A		
BY FUNI	11. MARITAL STATUS 1 Never Merried 2 Merried 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IF FORCES? 1 X YES IF YES, GIVE WAR OR D. Pre WWII	2 NO	ED)	II yes, sp	CENDENT OF HISPAN Decify Cuben, Mexice S 2 X NO Specify	n, Puerto		r No t4	Black, W Specify:	American Indi Inite, atc.	en,
LETED	ts. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12)	CATION completed) College (1-4 or 5+)	(Give	EDENT'S USU e kind of work of Do NOT use reti	done during mo			. KIND OF BUSH		TRY	7	
COMPL	17. FATHER'S NAME (First, Middle, Last)		<u> Fore</u>	man		18. MOTHER'S NA	ME (First,					
O BE	Sebastian Salir	na				and Number or Rural I	Route Num			ode)		
	Mrs. Grace Myers 20e. METHOD OF DISPOSITION 1 X Burlel 2 Cremetton 3 Rem 4 Donatton 8 Other (Specify)	oval from State 20t	b. PLACE AP	ND DATE OF DI	SPOSITION (Na	<u>k - Spark</u> _{ame of} r Cemeten	QA1	E 20c, LOC	ATION - CIT	y or Town,	State Mar	v1
	21. SIGNATURE REFUNERAL SERVICE LA	heled Le			22. NAME A	ard J. Ru Harford	CILITY					
	23. PART I. Enter the diseases, or shock, or heart failure. IMMEDIATE CAUSE (Final disease or condition resulting in death)	a. RES	PI PA	ATOR	4	FAIL	in	E	atory srres	t,	Approximinterval B	d De
CERTIFICATION	Sequentially list conditions, if sny, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	c. DUE TO (OR AS A	ERT A CONSEON	ENS	nos	TFA	7 LL	INB			YEAR 3 WE	RS
AL CEF	PART II. Other algnificent condition					ig cause given in	Part i.	24a. WAS AN A		24b. WI	ERE AUTOPSY I	
MEDICA				-			_	PERFORM		CC	MILABLE PRIOR DMPLETION OF F GEATH? YES 2 (1)	CAUSE
	DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL EXAMINER?	RIBUTE TO CAUSE O		OF OEATH (C			V 🗆					
Y PHYSICIAN:	1 VES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending Investigation	1 Vinpetlant 2 □ ER/Outs 28e. DATE OF INJURY (Month, Day, Year)	tpetient 3		Nursing Hon 28c, IN.	JURY AT DRK? YES 2 NO		or (Specify) SCRIBE HOW IN	JURY OCCU	RED		
ETED B	2 Accident Investigation 3 Suicide 8 Could not be 4 Homicide determined	28e. PLACE OF INJURY building, atc. (Spe	Y — At hon	ne, ferm, atree	t, factory, offic	Co		CATION (Street er or Town, State)	nd Number or	Rural Rout	le Number,	
COMPLE	100	ICIAN: To the best of my know ER: On the basis of exemination									nd manner as	stated
TO BE C	30. NAME AND ADDRESS OF PERSON WH	MEDICAL		CTO		PO 9	BER 30	6		SIGNED IM	onth, Day, Year,	190
	FRANCIS KWASH 31. DATE THEO MOND. POR DOOR		SE			ALITAN	Hosp	TAL OF	MARY	LAN) INC	5 0

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 5 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1. 2, 3 sho be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial. cremation, or removal. IMPORTANT: It item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
--

	1 - FOR STATE REGISTRAR	STATE OF MARYLA		TMENT OF I		MENTAL HYGIEN				
	1. DECEDENT'S NAME (First, Middle, Last) ELSA L.		T	ERUEL		2. DATE OF DEATH DOUBLE DECEMBER	13. 195	3. TIME OF DEATH 4:52 A M		
	The second secon		AGE (In yrs. lest birthday) IF UNDER 1 YEAR IF UNDER 24 HOURS M			7. DATE OF BIRTH (Month, Day, Your) Feb. 5, 19	BIRTHPLACE (State or Foreign Country) UETTO Rico			
OR	96. FACILITY NAME (If not institution, give stre THE JOHNS HOPKINS				RE CITY	EATH	9c. COUNTY	OF DEATH N/A		
DIRECTOR	Md. Ann	ne Arundel	10c, CIT	y, town or Loca Odentoi				10d. INSIDE CITY LIMITS? 1 YES 2 NO		
FUNERAL	100. STREET AND NUMBER 547 G Tranquil Ct	t.		10	21113		109. CITIZEN	OF WHAT COUNTRY?		
В	11. MARITAL STATUS 1 Never Merried 2 Merried 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR DA	2 X NO	If yes, s				RACE - American Indian, Black, White, etc. Specify: Puerto Rican		
COMPLETED	15. DECEDENT'S EDUCA (Specify only highest grade of Elementary/Secondary (0-12)	completed) College (1-4 or 5+)	(Give kind of a life. Do NOT us	USUAL OCCUPATI work done during m se retired.)	ON	16b. KIND OF BU				
BE COMF	5 17. FATNER'S NAME (First, Middle, Last) Armando Teruel	N/A I	Chil	.0		Child ME (First, Middle, Maider I. Quinone				
TO B	19a. INFORMANT'S NAME (Type/Print) Elsa Teruel					Route Number City or Tov C., Caroli	na, Pue	rto Rico		
	206. METNOD OF DISPOSITION 1\(\) Burist 2 \(\) Cremation 3 \(\) There () 206. PLACE AND DATE OF DISPOSITION (Name of competery, crematory or offset place) Besurreccion Cemetery 206. LOCATION — City or Town, State Carolina, Puerto Rico 22. NAME AND ADDRESS OF FACILITY									
	22. NAME AND ADDRESS OF FACILITY Gary L. Kaufman Funeral Home of Elk., Inc. 5695 Main St., Elkridge, Md. 21227									
	23. PART I. Enter the diseases, or conshock, or heart feiture. L. IMMEDIATE CAUSE (Finel disease or condition resulting in deeth)	omplications that caused list only one cause or expenses of the cause	ech line.			71	elratory arreat	Approximata interval Between Onset and Death		
CERTIFICATION	Sequentially flat conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST ACUTE LYMPHOCYTIC IBUKEMIA REPORE 12 MONTH OF THE PROPRIET OF THE									
PHYSICIAN: MEDICAL C	NEUTROPENIA 1 YES 2 ONO OF D							24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO		
SICIA		HOSPITAL:	26. PLACE OF DEA	OTHER:		8 Dither (Specify)				
BY PHY	27, MANNER DF DEATN 1 Natural 5 Pending 2 Accident Investigation	28a. DATE OF INJURY (Month, Day, Year)	28b. TIA	4 Nursing Nome 5 Reside IME OF 28c, INJURY AT WORK? M 1 YES 2 N		28d. DESCRIBE NOW	INJURY OCCUR	ED		
6	2 Accident									
COMPLET	000)	CIAN: To the best of my know						ause(a) and menner as stated.		
BE C	29b. SIGNATURE AND TITLE OF CERTIFIER				29c. LICENSE NU		29d. DATE SI	IGNED (Month, Day, Year)		
0	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF DE			1 1	13 111	Dece	imber 17,1995		
	DOLORGES B. NOOK	32. REGISTRAR'S SIGN	ORTH WOL	FC STRE	ET RALL	MORE, MI	ARSLAN	10 21287		
	DEU1 91995	1 Devoter Co	Lat							

State of Maryland / Department of Health and Mental Hygiene 95 Certificate of Death

Physician	
/Medical	
Examiner	

Directo

Be

Funeral

Director 28a-1 show

permit. Peges 1 and 2 should be filed within 72 hours after deeth with the Maryla Department of Health and Mentel Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examena must be notified at

Baltimore, Maryland 21215-0020 Physician /Medical **Examiner**

Hospital or Attending Physician: The lew requires that the death certificate be executed certificate After this death. offer death
Diractor: / within 24 hours eft To the Funeral Discompletely filled in To the

Physician/Medical

þ

Completed

Be

Certification: To

Medical

Box 68760,

Division of Vital Records, P.O.

1. Decedant's Nama (First, Middle, Last) 2. Data of Death 3. Time of Death Month Edith Mabel Tea1 10:30 P.M. DEC 1995 14 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Catonsville Summit Nursing Home Baltimore If Under 1 Year If Under 24 Hrs. 8. Data of Birth (Month, Day, Yea JAN 16, 1 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 10 M 24 F 214-74-2886 91 Yrs. 1904 Maryland Usual Rasidance of Decedent 10e. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yas 2 No Catonsville Maryland Baltimore 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 1208 Westerlee Place, Apt. 1-D 21228 USA Funeral 12. Was Decedant Evar in U,S. Armed Forças? 1 ☐ Yas 2 No If Yas, Give 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puerto Rican, etc.) 11. Marital Status Black, Whita, etc. 1 Never Married 2 Married White 1 ☐ Yas 💥 No Specify: þ 3 Widowed 4 □ Divorced Year or Dates Completed 16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) Coilege (1-4or 5+) Homemaker 9 Home 17. Fathar's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maiden Sumame) Thomas P. Clark Josephine McKenzie 19a. Informant's Name/Relationship (Type, Print) 19b. Melling Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard T. Teal (Son) 1208 Westerlee Place, Apt. 1-D Balto., MD 21228 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramoval from State Metro Crematory, Inc. 12/15/95 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Cremation Society of Maryland, Inc. 21. Signatura of Funaral Service Licensea 299 Frederick Rd. Baltimore, MD 21228 George E. MacNabb 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediata Causa (Final disaasa or condition rasulting in death) a. JENERALISED ARTERISCLEROTIC CARDIOUASCULAR
Due to (or es e consequence of):

DISEASE DIABETES MELLITUS Dua to (or as a consequence of):

Sequentially list conditions, if any, laading to immadiata causa. Enter Underlying Cause (Disaasa or Injury thet initiated events resulting In daath) Last

Part II. Other algnificant conditions contributing to death but not resulting in the undarlying causa given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 Yes 22 No 3 Probably 4 Unknown

SEVERE OSTEOARTHRITIS LUMBAR SPINE

24a. Was an autopsy performed? 1 □ Yas 2 1 No

28d. Dascribe how Injury occurred

24b. Wara autopsy findings available prior to completion of cause of death? 1 Yas 2 No

25. Was casa raferred to medical examinar? 1 Yes 2 No

5 Pending Invastigation

6 Could not be

28a. Deta of Injury (Month, Day Year)

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of

Plece of Injury - At homa, farm, street, fectory, office bullding, atc. (Specify)

Other: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) 28c. Injury at Work? 1 Yes 2 No

26. Piace of Death (Check only one)

Location (Street and Number or Rural Route Number, City or Town, State)

29e. Cartifiar

27. Menmer of Death

1 Netural

2 Accident 3 Sulcida

4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 2 Medical Examinar: On the besis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated.

29b. Signature and titia of certifiar

29c. Licensa number

29d. Data signed (Month, Day, Year)

30. Nama and addrass of person who completed cause of thath (Item 23a) (Type, Print)

3455 WILKENS AVE., BALTIMORE MD 21229 32. Begistrar's Signatura

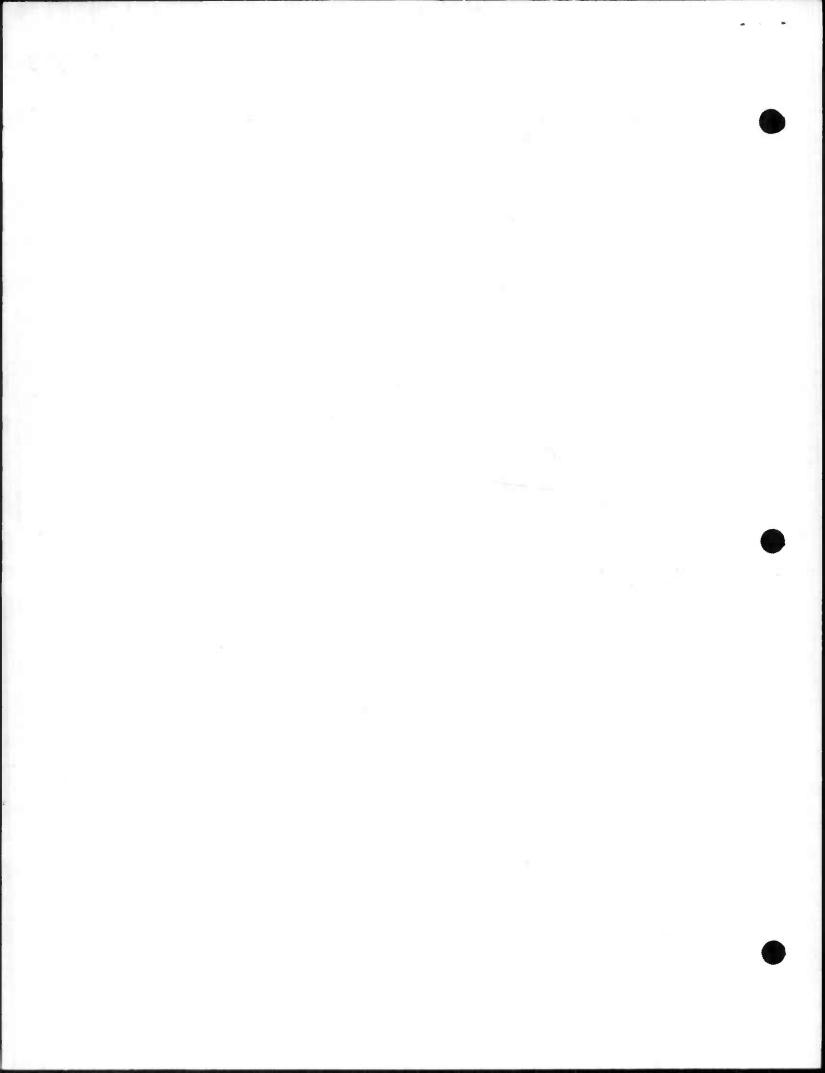
State Registrar

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	TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the host	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detache	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: if item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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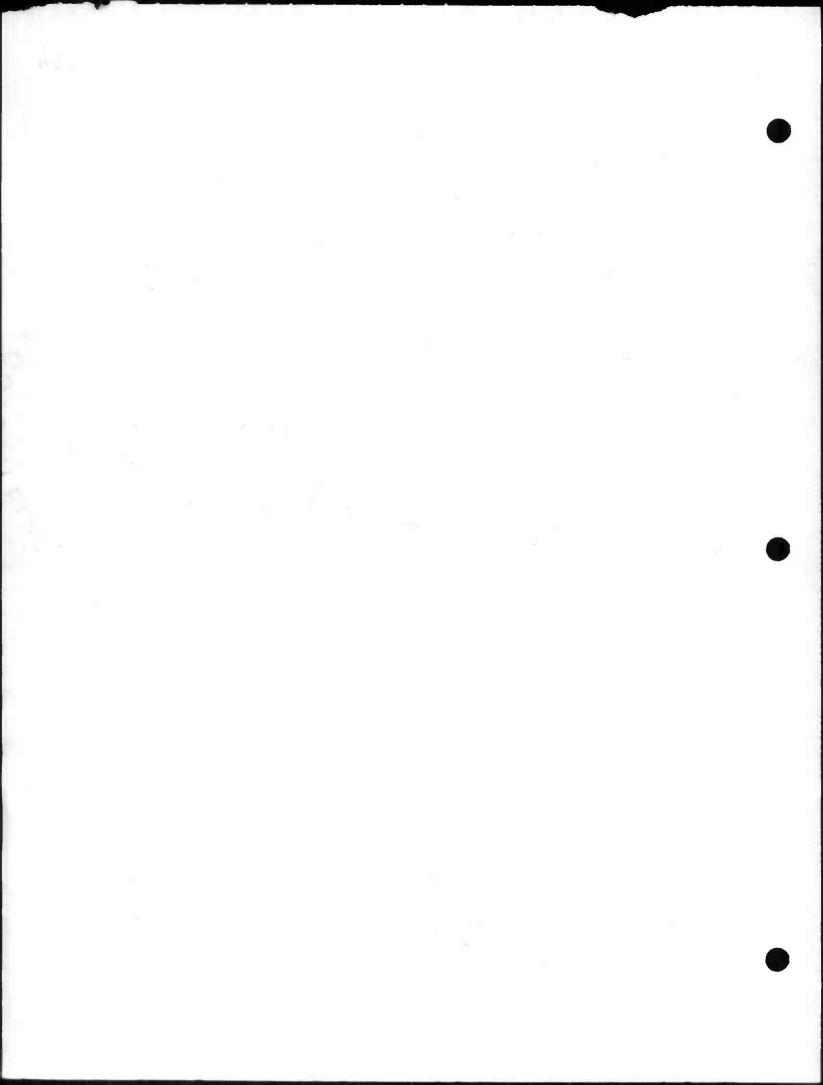
	1 - STATE REGISTRAR	STATE OF MARY		MENT OF I		MENTAL HYGIEI		0 00000		
	1. DECEDENT'S NAME (First, Middle, Last JOSEPH ROB	,	CEK		2. DATE OF DEATH DECEMBER		3. TIME OF DEATH			
	4. SOCIAL SECURITY NUMBER 213-28-7542	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH 05-06-193	BIRTHPLACE (State or Foreign Country) RYLAND						
TOR R	9a. FACILITY NAME (If not institution, give 240 SHELIA K. CO			96. CITY, TOWN SEV	ERN	EATN	9c. COUNTY ANNE	OF DEATH E ARUNDEL		
DIRECTOR	10a. STATE 10b. COUN	ANNE ARUNDEL		TOWN OR LOCA	TION	10d. INSIDE CITY LIMITS? 1 YES 2 NO				
FUNERAL	106. STREET AND NUMBER 240 SHELIA K. CO	URT			2114	4		J.S.A.		
B	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER FORCES? 15 YES IF YES, GIVE WAR OR KOREA		If yes, sp		NIC ORIGIN? (Specify Years, Puerto Rican, etc.)	s or No 14.	RACE — American Indian, Black, White, etc. Specify: WHITE		
COMPLETED	15. DECEDENT'S ED (Specify only highest grac Elementary/Secondary (0-12)		16a. DECEDENT'S U (Give kind of we life. Do NOT use EQUIPMENT	retired.) HEAV	ost of working	166. KIND OF BU				
ВЕ СОМ	17. FATHER'S NAME (First, Middle, Last) JAMES	11/11	VACEK	OI BIUI		AME (First, Middle, Melder	Surname) BRU	JSH		
10	19a. INFORMANT'S NAME (Type/Print) JOSEPH C. VACEK		196. MAILING / 6526 CI	EAR DRO	P CT.,	APT. 203,	on, State, Zip Coo GLEN BU	JRNIE, MD.21060		
	20e. METNOD OF DISPOSITION 1 Buriel 2 Cremation 3 1 4 1 Donation 8 0t	GI GI	Db. PLACE AND DATE OF	MEMORIA	L PARK	1995 GLE	N BURNI	E, MD.		
	21. SIGNATURE OF THERAL SERVICE L	DENNEE .	-			CILITY SINGLE	TON FUN	NERAL HOME, RNIE,MD.21061		
	23. PART I. Enter the disease, or shock, or lisert fellure IMMEDIATE CAUSE (Final disease or condition resulting in death)	e. ACUTG DUE TO (OR AS	COCONIA CONSEQUENCE OF)	m,			iratory arreat	Approximate Interval Between Onset and Dasth		
ERITICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that Initiated events resulting in death) LAST b. H496n 76nSLON DUE TO (OR AS A CONSEQUENCE OF): T496 CH276 76nULOW LA DUE TO (OR AS A CONSEQUENCE OF): TUBER TO (OR AS A CONSEQUENCE OF):									
CALC	PART II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? AMAILABLE PRIOR TO									
K: MEDIC	DID TOBACCO USE CON	TRIBUTE TO CAUSE (OF DEATH YES	NO E	1 UNCERTAL	1	2 DNO	COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO		
PHYSICIAN:	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN D 25. WAS CASE REFERRED TO MEDICAL EXAMINER? DISCUSSION HOSPITAL: 1 Inpetient 2 ER/Outpetient 3 DOA 4 Nursing Nome 5 Residence 8 Other (Specify)									
N PH	27. MANNER OF DEATH 1 Maturel 5 Pending Investigation	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME INJU	RY WO	URY AT PRK? YES 2 NO	28d. DESCRIBE HOW	INJURY OCCUR	EO		
- 11	289. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 281. LOCATION (Street and Number or Rural Route No. City or Town, State)									
COMPLEIED		SICIAN: To the best of my know IER: On the basis of examination						use(a) and manner as stated.		
	29b. SIGNATURE AND TITLE OF CERTIFIE	7			29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) 12-14-9 (
	30. NAME AND ADDRESS OF PERSON W 277 PGM A 31. DATE FILED (Month, Day, Year)	SUIA 1	Jan 100	rint)	Anni	ry M	1 2	101 2		
	DEC1 91995	32. REGISTRAR'S SIGN	Hall					DHMH-18 Rev 1/89		





TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatte event, the medical examiner must be notified at once.

	FOR 1 - STATE REGISTRAR	STATE OF MARYLAND		MENT OF H		MENTAL HYGI				
	t. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATI	1	3.	TIME OF OEATH	
ľ	011a		VANHOY			December	15 199	EAR 2	2:30	Ам
		SEX 6. AGE (In yrs.		IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH	8.	BIRTHPLA	CE (State or Foreig	
	2 3 3 3 2 3 .	□ M 2 🔭 7	B YRS.	ONTHE DAYS		July 15,	1917	Virg	inia	
_	9e. FACILITY NAME (If not institution, give street		1	B. CITY, TOWN O	R LOCATION OF DE		9c. COUNTY	OF DEATH	1	
DIRECTOR	Franklin Square	Hospital			Rossvi	11e	Balt	imore	3	
Ä	10e. STATE tob. COUNTY		t0c. CITY,	TOWN OR LOCAT				tod	I. INSIDE CITY	
		imore			Middle	River			YES 2 NO)
FUNERAL	toe. STREET AND NUMBER			101	ZIP CODE		10g. CITIZEN	OF WHAT	COUNTRY?	
Ä	42 S. Randol				212			SA		,
5	t1, MARITAL STATUS t2 1 Never Merried 2 Merried	. WAS DECEDENT EVER IN U.S. FORCES? t YES 2	ARMED NO			HC ORIGIN? (Specify n, Puerto Rican, etc.		Black, WI	American Indian, hite, atc.	
ВУ	3 Widowed 4 Divorced	IF YES, GIVE WAR OR DATES	X	t 🗆 YES	2X NO Specify	r:		Specify:	n. t. i.	
	15. DECEDENT'S EDUCATI	ON I see	DECEDENT'S III	SUAL OCCUPATION	M.	ASS VIND OF	BUSINESS/INDUS		hite	
	(Specify only highest grade com	pleted)		rk done during mo:		tea. KIND OF	DOSINESS/MDOS	161		
2	Elementery/Secondary (0-12) C	ollege (1-4 or 5+)	Ноис	ewife			own ho	m 0		
COMPLETED	17. FATHER'S NAME (First, Middle, Last)		nous	ewile	** MOTHED'S NA	ME (First, Middle, Me		lile		
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BE	tiga, INFORMANT'S NAME (Type/Print)		105 MAILING A	DDDECC (Street o		OLA — Route Number, City or		oda)		
2	Buck Cork					Morgan			26505	
	20a. METHOD OF DISPOSITION	205 81 6		DISPOSITION (Na			LOCATION — CITY			
	X XBurial 2 Cremation 3 Removal 4 Donetion 5 Other (Specify)	from State cematery.	crematory or other	er place)						
	21. SIGNATURE OF FUNERAL SERVICE LICENS		ly Hil		D ADDRESS OF FA	2/18/95	Balti	more	Mq.	
	DT	10 1	1			uneral	Home o	f Fc	SAY	
	1. lerry	Connel	las	300	Mace A	ve Ral	timore	-Md	21221	1
	23. PART I. Enter the diseases, or com- shock, or heart failure. List	plicetions that caused the	death. Do no	t anter the mo	de of dying, suc	h aa cardlac or n	eapiratory arrest		Approximata	
	IMMEDIATE CAUSE (Final									
	disease or condition resulting in death)	Bronchiectasi	S						6 year	rs
Z	Commentative list and distance of b.									
Ĕ	Sequentially list conditions, If any, leading to immediate									
2	cause. Enter UNDERLYING CAUSE (Disease or Injury									
	that initiated events resulting in deeth) LAST	DUE TO (OR AS A CON	ISEQUENCE OF):							
CERTIFICATION	d									
AL C	PART II. Other significent conditions of	ontributing to death but n	ot reaulting in	the underlying	g ceuse given in		S AN AUTOPSY		RE AUTOPSY FIND	
2	Breast cancer, Rh	eumatic heart	diseas	se with	mitral		S 2 X NO	co	VILABLE PRIOR TO MPLETION OF CAU	
	stenosis, atrial					`` "	3 2 [] 110		DEATH? YES 2 NO	
2	DID TOBACCO USE CONTRIB		EATH YES	П №	UNCERTAI	N D			_ 123 2 _ 110	
PHYSICIAN: MEDIC	25. WAS CASE REFERRED TO MEDICAL			(Check only one)						
SIC		OSPITAL: tnpetient 2 = ER/Outpetien		OTHER:	e 5 Desidence	6 Other (Specify)				
Ή	27. MANNER OF DEATH	28e. DATE OF INJURY	26b. TIME	OF 28c. INJ	URY AT		OW INJURY OCCUP	RED		
	t Netural 5 Pending	(Month, Day, Year)	INJUI	RY WO	RK7 YES 2 NO					
ВУ	2 Accident Investigation 3 Suicide 6 Could not be	26s. PLACE OF INJURY - A	t home, ferm, atr	reet, factory, offic			reet and Number or	Rural Route	Number,	
回	4 Homicide determined	building, etc. (Specify)				City or Town, S	itate)			
COMPLET	29a. CERTIFIER & CERTIFYING PHYSICIA	N: To the best of my knowledge	death occurred	at the time date	and place, and due	to the councie) and	manner an eleted			-
Σ	need.	On the basis of exemination and							d menner as efst	art
29c. LICENSE NUMBER 29d. DATE SIG								2-15		
2	30. NAME AND ADDRESS OF PERSON WHO C	OMBI ETED CALIDE OF DE TO	OTEM OF CO.	Terinos I	D30263		1	-13	-13	
					4					
	Francis Khoo MD 900	JU Franklin S	quare I	orive Ba	altimore	Maryland	1 21237			
	DECI 9 1995 Juli	22. REGISTRANCE SIGNATUR								



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 95

	•					Cer	tificate of	Death			Reg. No.		
	Dhuala		1. Decedent's Neme (First, Middle, La	st)						2. Dete of De	eth Dev	Year	3. Time of Deeth
	Physic /Medi		LUCILLE	Ε.		WC	DLFORD			DEC.1		1 Gal	19:15 P
Ţ	Exami		4e. Facility Neme (If not Institution, giv	e street end number)				4b. City, To	wn, or Loc	ation of Deet	4c. County	of Deeth	
			3700 GREENSPRI						CIMO			N/A	
	Funeral Director		21/ 12 3010	7. Age (f	n yrs. lest bir 2	thday) Yrs.	Months Deys		24 Hrs. Min.	8. Dete of Bir Month, Da DEC 2	th 71923	9. Birth	place (Stete or Foreign MD
	and and		Usuel Residence of Decedent 10a. Stete 10b. County	10	Oc. City, Tow	n or Loc	cation					Τ.	Od, Inaide City Limits
	Mary	ō	MD N/A		BA	LTO	1						YOYes 2□No
	r 28s	Director	10e. Street and Number				10f. Zlp Code				10g. Citizen of	Whet Cou	ntry?
	h with	a D	3700 GREENSPRI	NG AVE A	PT 30	6	21	211			US	SA	
020	deet	Funeral	11. Meritei Stetus	12. Wes Decedent Eve Armed Forces?	r in U,S.	13. V	Vas Decedent of Yes, specify Cul	Hispenic Ori	gin? (Spec	ify Yes or No			can indien,
	d 2 should be filed within 72 hours after deeth with the Maryland th and Mental Hygiene. 7 is marked other than "natural", or items 23s or 28s-f show traumatic avent, the Medicel Examinet must be notified at	by	1 ☐ Never Merried 2 ☐ Merried 3☐ Wildowed 4 ☐ Divorced	1 Yes 2 No If Yes, Give Yeer or Detes:			☐ Yes 2 No			iican, etc.)		ck, White, by: BL	
5-0	72 h	Completed	15. Decedent's Ed (Specify only highest gra	ducation	16e.	Deced	ent's Uauel Occu	petion a during mos	t of workin	a	16b. Kind of B	usiness/In	dustry
2	han .	mpi	Elementery/Secondary (0-12)	College (1-4or 5+)		life. D	O NOT use retir	ed)			ш	MEC	
7	Hygie ther nt, th		1 OTH 17. Fether's Neme (First, Middle, Last,	N/A		DO	MESTIC	18 Moths	ar's Alama	/Einst Middle	Meiden Sumer	OMES	
Marylan d 2 should be	Mental I Merked of mrtic ave	To Be	JOSHUA FRAZI			_		CLA		DIGGS		110/	
			19e. Informent'a Neme/Reletionship (MARY POLLARD		19b. Melling Address (Street end Number or Rurel Route Number, City or Town, 5724 WINNER AVE BALTO, MD 21							Code)	
altimore,	ages ant of it: If it y or c		20e. Method of Disposition 1 Buriel 2 □ Cremetion 3 □ 4 □ Dongtion 5 □ Other (Specification of the content	Removei from State	20b. Plece of cemete. PLES	Dispos ry, crem ANT	eition (Neme of letory or other pi	ece)	122	Dete 2095	20c. Location Towson	100	own, Stete
a	Departm Departm Importan any injur		21. Signature of Funerei Service Lices	cop N		22.	Neme end Addi	ress of Fecilit	ty				-
m	82 = 2		I CHAME !	1 Jhm	DSM	MA	RCH F/	H-WES	ST 43	300 W	ABASH A	AVE	
	Physician /Medical		23e. Pert1 Inter the disease, or com shoot, or heert feilure. List only Immediate Dause (Finel	one ceuse on each line.	v								Approximete intervel Between Onset and Deeth
	Examiner		diseese or condition resulting in deeth)	Arteriosc	lerot			ovasc	ular	Dise	ase		
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,	certificate be assouted nding physician and use as the burial-transit	Examiner	Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury	b. Due	e to (or es e	consequ	uence of):						
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m	0 0 %	Physician/	Pert II. Other significent conditions of	ontributing to deeth but n	ot resulting in	n the un	derlying cause g	iven In Pert I		23b. Dld	tobacco use co	entribute t	o the cause of death?
<u>о</u>	res that the de igned by the e be detached f	Phy								10	Yes 2 No	3 □ Pro	bably 4 Unknown
	igned be d	by											
Records,	law requires thet that so been signed by the 2 should be detached.	Completed									en eutopsy rmed?	94	ere eutopsy findings eileble prior to
ec	hes b	oldu								INSPE	CTION	of	mpletion of cause death?
	Page ate									10	Yea 2 No	1[Yes 2 XNo
VII	Physician: The this certificate iral director, pag	Be	25. Was case referred to medical examiner?	Hospitel:			_ 0	thor:		(Check only			
ō	Physic rthis oral dir	. To	1)X Yes 2 No 27. Menner of Deeth	1 Linpatient		itpetient Time of	3LI DOM	4 🗆 140		-	dence 6 Oth		(y)
O	th. After funer	tion	1 Naturel 5 ☐ Pending Investigation	28a. Date of Injury (Month, Dey Ye	ear) I	njury	28c. inje We	ork?]Yes 2 □:			non injury coods		
Division	Attending or death. ector: After by the fune	Iffice	3 ☐ Suicide 6 ☐ Could not be determined	200. Place of injury	At home, fa	rm, stre	et, fectory, office	•	2			ber or Run	ai Route Number,
בֿ	a # F =	Certification:	4 Hornicide	building, etc. 75	Бреспу)					City or To	MT, Stete)		
	Hos Fun tely	edical	29a. Certifier (Check only one) 1 Cartifying Ph	ysician: To the best of m hinar: On the basis of exe end menner steted	eminetion en	, deeth d/or inve	occurred et the t estigetion, in my	ime, dete en opinion, dee	d piece, ar th occurre	nd due to the d et the time,	ceuse(s) end m date end plece,	enner as a end due t	tated. o the ceuse(s)
	To the Within 2 To the comple	Σ	29b. Signature end title of certifier	1.			29c. Licen	se number			29d. Dete signe	ed (Month,	Day, Year)
			German	Chutens			00	CME			DEC.1	5.19	95
	Ц	Ì	30. Neme and eddress of person who	completed cause of deeth	(Item 23a)	Type, F					220.1	-117	
			Dennis Chute N	1.D. 111 P	enn S	Str	eet, Ba	altim	ore,	Mary	land 2	1201	
	Sta Registr	_	31. Dete filed (Month, Dey, Yeer) UEU1 91995	32. Registrer's	Signeture								
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28	Signa	prior to

injury, or other traumatic event, the medical examinor must be notified at once,

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law incurrent TO THE FUNERAL DIRECTOR: After this certificate has the topic be filed within 72 hours after death with the State Dept. If Item 28 is marked, or item 23 how may

DIVISION OF VITAL RE

BALTIMORE, MARYLAND 21215-0020

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	MEGISTHAH		CENTIF	TOATE	JF DEATH	RE	G. NO.		
	1. DECEDENT'S NAME (First, MICHOE, Last) MILDRED LEAH SEIDEL MAGNER 2. DATE OF DEATH MONTH DAY YEAR 3. TIME OF DEATH								
	4. SOCIAL SECURITY NUMBER		37701	0 3					12-30 am
	212 090815	5. SEX 6. A	GE (In yrs. last birthday) YRS.	MONTHS DA	EAR IF UNDER 24 HRS. NYS HOURS MIN.	7. DATE OF BIF (Month, Dey, April 12	Ybar)	Count	PLACE (State or Foreign 7)
	9e. FACILITY NAME (If not institution, give	street end number)		9b. CITY, TO	WN DR LOCATION OF D			UNTY OF C	
œ	Church Home					CAITI			CAIN
DIRECTOR	RESIDENCE OF DECEDENT			L Bal	timore		N/A	A	
ii l	10e. STATE 10b. COUNT	Υ	100 00	Y, TOWN OR L	OCATION				
<u>c</u>				_					10d. INSIDE CITY LIMITS?
- 1		cimore	Ba	lltimor	e				1 TES 2 NO
₹	10e. STREET AND NUMBER				10f. ZIP CODE		10g. CI	TIZEN OF V	WHAT COUNTRY?
FUNERAL	3516 Wheelhouse H	Road			21220		111	S.A.	
3	11. MARITAL STATUS	12. WAS DECEDENT EV	ER IN U.S. ARMED	13, WAS	DECENDENT OF HISPA	NIC DRIGIN? (Spe			
	1 Never Married 2 Married	FORCES? 1 Y		If yo	s, specify Cuban, Mexic	en, Puerto Rican, e	rtc.)		E — American Indian, k, White, etc.
B	3 X Widowed 4 Divorced	IF TES, GIVE WAY D	H DATES	טי	YES 2 NO Speci	γ:		Spec	white
۵	15. DECEDENT'S EDI	CATION	18e. DECEDENT'S	HELIAL OCCU	BATION	T 464 MININ	OF BUSINESS/IN		WILLEC
	(Specify only highest grad	o completed)	(Give kind of life. Do NOT u	work done durin	g most of working	100. KINO	OF BUSINESS/IN	IUUSTRY	
ן ב	12 years	College (1-4 or 8+)							
Ξ			Execu	tive S	ecretary	Co	rporate	9	
COMPLETED	17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NA	ME (First, Middle,	Malden Sumame)		
H	William		Seidel		Margai	et		Swa	ffield
	19a. INFORMANT'S NAME (Type/Print)		19b. MAILING	ADDRESS (St	reet and Number or Rural	Route Number, City	or Town, State, Z	ip Code)	
임	Mr. Robert H. Bow	7en	4203	Sutton	Drive Mor	okton M	m 21111		
	294 METHOD OF DISPOSITION		20b. PLACE AND DATE				Noc. LOCATION -		
	20a METHOD OF DISPOSITION 1 N Burlel 2 Cremetion 3 Ren 4 Denation 5 Other (Specify)	novel from State			etery Dec.				
	21. SIGNATURE OF FUNERAL SERVICE LI	codese A	Dougou Fa.				Baltimo	re, I	Maryland
- 1		1) 1/			chell-Wied		T		
- 1	hours	(buech)	101						4.0
	23. PART I. Enter this diseases, or complications that caused the death. Do not enter this mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between								
	IMMEDIATE CAUSE (Final disease or condition		0	11	/	No.			Onset and Death
	resulting in death)	· Cong	estive	Hea	N Ja	lure			
		DUE TO (OF	AS A CONSEDUENCE O	F):	1	ulzu			
Z	Sequentially list conditions,	· Chron	ic ob	dry	clive of	u/su	mary	de	san
CERTIFICATION	If any, leading to immediate	DUE TO (OR A	AS A CONSEQUENCE O	F):	NE CONTRACTOR				
5	CAUSE (Disease or Injury	· Can	eralise	ol -	masar	ica.	,		
=	that initisted events	DUE TO (OR A	IS A CONSEQUENCE O	P31					
	resulting in death) LAST	· Ar	emo						
5									
3	PART II. Other significant condition	ns contributing to deat	h but not resulting	in the under	lying cause given in	Part I. 24a, V	WAS AN AUTOPSY	24b	WERE AUTOPSY FINDINGS
5 1				15			1 YES 2 NO		COMPLETION OF CAUSE
ED						_			OF DEATH?
	DID TOBACCO USE CONT	RIBLITE TO CALISE	OF DEATH VI	S D NO	UNCERTAI				1 YES 2 ND
A	25. WAS CASE REFERRED TO MEDICAL	MIDDIE TO CAUSE	26. PLACE OF DEA			и Ц			
HYSICIAN: M	EXAMINER?	HOSPITAL:		OTHER:	one)				
2	1 YES 2 NO	1 Inpatient 2 NER/O	Durtpatient 3 DOA		Home 5 - Residence	6 Other (Speci	fy)		
E	27. MANNER OF DEATH	28e, DATE OF INJUI (Month, Day, Yea		E DF 28c	INJURY AT WORK?	28d. DESCRIBE	NOW INJURY OO	CURED	
9	4 Netural 5 Pending 2 Accident Investigation	(, , , ,		YES 2 NO				
	2 Culate	28e. PLACE OF INJ	URY — Al home, Jerm,	street, factory,	office	281. LOCATION	Street end Numbe	or or Rural F	Route Number
4 Nomicide determined determined									
4	29e. CERTIFIER								
(Check only 1 CENTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner ea									
5	2 MEDICAL EXAMINI	ER: On the beele of examin	ation end/or investigation	en, in my opinic	on, death occured at the	lime, date and pl	ace, and due to t	the cause(e) end manner ee stated.
	29b. SIGNATURE AND TITLE OF CERTIFIE	R			29c. LICENSE NUI	ABER	294 DA	TE SIGNED	(Month, Day, Year)
	MKN8.15	40			D 1640		. Ju. (JA)	17/	1795
2	30. NAME AND ADDRESS OF PERSON WI	O COMPLETED CAUSE OF	DEATN (ITEM 27) (F	Print!	10 10 10	~		()	1/10
	Church Hospe	les Ex	100 14.15		thay 1	3715	MD	21	123)
	DEC1 9 1995	32 REGISTRAM'S S	IGNATURE		1				-
- 11	- 1000	11	ATTENDED						

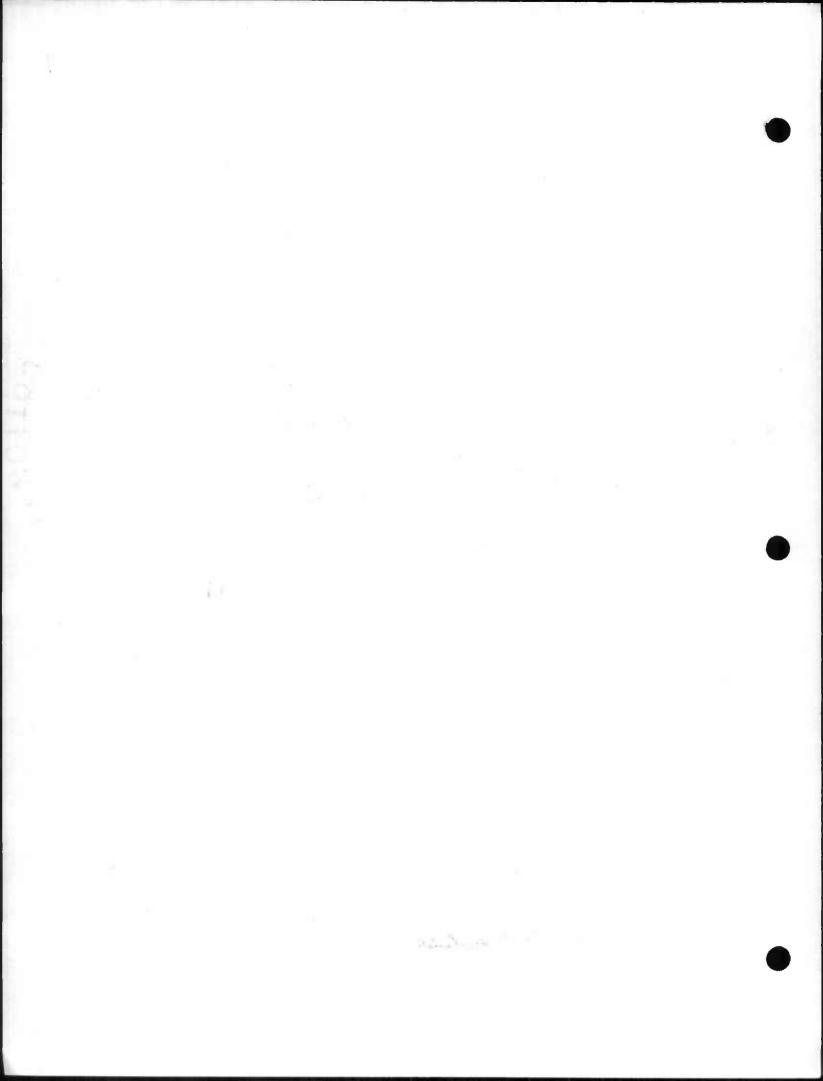
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DNMH-16 Rev 1/89

NG PHYSICIAN: The law requires that the death certificate be executed within Z4 hours after death. Page 6 may be retained by the hospital or attending physician.	0 THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burlal-transit permit. Pages 1, 2, 3 should	eath with the State Dept. of Health and Memfal Hygiene prior to burial, cremation, or removal.	marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires	TO THE FUNERAL DIRECTOR: After this certificate has been sign	be filed within 72 hours after death with the State Dept. of Healt	IMPORTANT: If item 28 is marked, or item 23 shows

	1 - FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.											
	1. DECEDENT'S NAME (First, Middle, Last)			02	IOAII		DEMI		OF DEATN			3. TIME OF DEATH
	CLARA (2.	WILLI	S				December 18 1995				1040 PM
	SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTY (Month, Day, Year)									8. BIRTH Count	HPLACE (State or Foreign	
	219 22 5848	1 □ M 2 💢 F	6	7 YRS.					ary7,1			aryland
œ	96. FACILITY NAME (If not institution, give s Stella Maris Hosp				96, CITY	, TOWN C	R LOCATION OF DE	EATN			NTY OF D	
6	RESIDENCE OF DECEDENT				Towson			Ŀ	Balt:	imore		
DIRECTOR	10a. STATE 10b. COUNT			10c. Cl	TY, TOWN C	R LOCAT						10d. INSIDE CITY LIMITS?
	Maryland toe. STREET AND NUMBER	Ceci1				1 101	Conowing	go		1 YES 2 NO		
RA	4 Woodside Dr.			100	21918					d States		
FUNERAL	11, MARITAL STATUS	S. ARMED			ENDENT OF NISPAN				14, BAC	E — American Indian,		
ВУ Е	1 Never Married 2 Married 3 Widowed 4 Divorced	IF YES, GIYE	1 YES				2 NO Specify		Rican, atc.)		Spec	k, White, stc. White
	15. DECEDENT'S EDU	CATION	10	sa. DECEDENT'				166	. KIND OF BUS	INESS/INF	MISTOV	MIIICE
COMPLETED	(Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4 or 5		(Give kind of life. Do NOT	work done	during mo	st of working	100	. KIND OF BOS	1142371142	7031RT	
APL.	7			Si1k	Scre	ener				Fact	ory	
00	17. FATNER'S NAME (First, Middle, Last) John F	11		0.1			18. MOTNER'S NA		Middle, Maiden S	Surname)		
BE	19a, INFORMANT'S NAME (Type/Print)	lmer		Cu1			Minni					derwood
2	Robert Willis						nd Number or Rural					4.0
	20e. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or										own, Stata	
	t X Buriel 2 Cremation 3 Rem 4 Denation 5 Other (Specify)	oval from State	- Maj	ry, crematory or ryland	other plece) Vete	rans	Cemeter	cv 12	/22/95	Ga	rris	on Forest
	21. SIGNATURE OF FUNERAL SERVICE LI	SHEET			22,	NAME AL	tephen I	CILITY				
	> Stola A TX	Huna	m									e,MD 21286
	23. PART I. Enter the diseases, or ahock, or heart failure.	complications the	at caused ti	he death. Do	not enter	the mo	de of dying, suc	h se cere	disc or respir	ratory sr	reat,	Approximate interval Between
ahock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition at LUNG CANCER as LUNG CANCER												Onset and Death
	resulting in death)							140.				
_	DUE TO (OR AS A CONSEQUENCE OF):											0
CERTIFICATION	Sequentially list conditions, If any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF):											
CA	cause. Enter UNDERLYING CAUSE (Disease or Injury	c	0.400.40.4.0	ONSEQUENCE (
1	that initiated events resulting in death) LAST	DOE II	O (OH AS A C	UNSECUENCE	JF):							İ
S		d										+
ÄL	PART II. Other significant condition	na contributing to	o death but	not resulting	in the ur	nderlyin	g cause given in	Part I.	24a. WAS AN		24	b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
D)									1 TYES 2	X(NO		OF DEATN?
M	DID TOBACCO USE CONT	DIRLITE TO C	ALISE OF	DEATH V	ES 🗆	NO	UNCERTAI	N [1 PYES 2 NO
PHYSICIAN: MEDIC	25. WAS CASE REFERRED TO MEDICAL	KIDOTE TO C.		PLACE OF DE			UNCERIA			_		
SIC	EXAMINER?	HOSPITAL:	☐ ER/Outpati	ant 3 🗆 DOA	OTHE		e 5 🗆 Reeldenca	6 Nothe	r (Specify)	Hosi	oice	9
PHY	27. MANNER OF DEATN	26a. DATE O (Month,	Day, Year)	26b. Ti	ME OF	26c. INJ WC	URY AT	28d. DE	SCRIBE NOW IN			
В	1 Natural 5 Pending 2 Accident Investigation				M		YES 2 NO					
ED	3 Suicide 6 Could not be 4 Homicide determined	building	g, etc. (Specify,	At home, lerm	street, lac	tory, offic	•		ATION (Street a or Town, State)	nd Numbe	r or Rural	Route Number,
COMPLETED	29a. CERTIFIER 1 CERTIFYING PHYS	ICIAN: To the heat	of one knowled	lan double annu		des de		4	con size to	-0.1.14		
MP	enci only											s) and manner on stated.
	296, SIGNATURE AND TITLE OF CERTIFIE						29c. LICENSE NU					D (Month, Day, Year)
) BE	X gradale	Cha	ulk	alin	0		D05	64	3	▶ la	- 1	1
2	30. NAME AND ADDRESS OF PERSON WA	O COMPLETED CA										
	DR. KENDALL FA	ULKNER			ANEY	VA	LLEY R	D.,	TOWSO	N,M	D :	21204
	31. DATE DE WOT, DE 1995	32. REGISTE	RAR'S SIGNAT	URE								
				-								





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

					(Certificat	e of D	Death	R	eg. No.		
П			1. Decedant's Name (First, Middle, La.						2. Dete of Deel	h	Levis	3. Tima of Death
	Physic		WILLIAM H.	ENRY WAL	GENI	FOEHR			Month	Day	/995	8.20pm
	/Medi Examir		4a. Facility Name (If not institution, give	a street and number)	<i>3</i> L/Y ¹	URIII	4b	c. City, Town, or	Location of Death	4c. County		gepin
			FALLSTON GE	WERAL HE	1501	fal		FAILS	TOAL	HI	912 FOI	RA
	Funeral		5. Social Security Number 6. S	Sax 7. Aga (In yrs	. last birth			If Undar 24 Hrs				aca (Stata or Foreign
	Director		218-07-1682 Usual Rasidance of Dacedani	20 M 2□F 83	- Y	Months	Days	Hours Min.	OCT 6	1910	Count	EYLAND
	ylan		10a. Stata 10b. County	10c. C	ity, Town	or Location					10	Od. Inside City Limits
	Mar Mar	tor	MD BALT	IMORE	WI	HITE HI	766					1 ☐ Yas 2 Mileo
	h th	Director	10e. Street and Numbar			10f. Zip			1	0g. Citizan of \	What Count	iry?
	h wi		4252 HAREDRI	O CREAMER	UR	0	2116	/		1).	5.A.	
	daa	Funeral	11. Maritei Status	12. Was Decedent Ever in Armed Forces?	u,s.	13. Was Deced	dent of His	penic Orlgin? (S	Specify Yes or No- to Rican, atc.)	14. Rac	e - America	
215-0020	hours after death with the Maryland uret, or items 23s or 28s-f show at Examiner must be notified at	by	1 Navar Married 2 Merried 3 Widowed 4 Divorced	1 Yas 2 Mo If Yas, Giva Yaar or Datas:		1 ☐ Yas		Specify:	to Rican, atc.)	Specify		HITE
0	n 72 hours "natural", notical Exe	ted	15. Decedent's Ed		16a. [ecedant's Usue	Occupat	tion		16b. Kind of B	V -	
215	- A	Completed	(Specify only highast gra	Collega (1-4or 5+)	- (iifa. DO NOT us	rk dona di sa retired)	uring most of wo	rking	,		
2	77 70 10 10	OT	8485			MAC	HIN.	£3T		KOP	DER S	5 Co.
bu		Be	17. Father's Nama (First, Middla, Last)					18. Mothar's Na	ma (First, Middle, I			
Maryland		70	CHARLES WIL	AGEN FUEH	R			CAROL	INE ER	BES		
an	d 2 should th and Mer 7 is marks traumatic		19a. Informant's Neme/Ralationship (Malling Addrass			ural Routa Number		Stata, Zip	Code)
Σ	27 le		MRS WILLIAM W) AGEN FUETHR	2 42	52 /4	ARFO	RED CRE	MERY	RD	211	61
ore	of Haall of Haall I Item 2 r other		20a. Mathod of Disposition	20b.	Place of I	Disposition (Nan cramatory or o	na of			20c. Location -	City or Tov	wn, State
Baltimore	Pages natr of mt: # ite		1 Burial 2 □ Cramation 3 □ 4 □ Donetion 5 □ Othar (Spacify	mamoval flom Stata		N5 211		Cm.	12/11	SWEET	- DI	
	교통원류.		21. Signature of Funeral Service Licen	31.	JUH	22. Nama an	d Address	of Facility			1111	
ä	Depa Impo		10010	. /					F CHIMA			
			Draws Port	(NO.25)	4 D				Mon		2109	Was a state of the
			23a. Part1. Entar tha disaasa, or com shock, or haart failura. List only	ona causa on aach lina.	ith. Do no	t antar tha mod	e ot dying	, such as cardie	c or respiretory are	est,		Approximete Intarval Batween Onset and Death
D	Physician / /Medical		Immediate Course (Final	- 1								Oriset and Death
	Examiner		Immediata Causa (Final disaase or condition rasulting in daath)	· Sepsis							10	Jours
		70	The second secon	Dua to	or as a co	nsequance of):					1	7
	pe tist	Examiner		6. Right Low	cr	Lobe	I'ne	monio				Jays .
	and and I-trar	xar	Sequantially list conditions, if any, leading to immediate	Dua to	oras a co	nsequance of):						9
68760,	be executed sician and burial-transit		Sequantially list conditions, if any, laading to immadiata cause. Entar Underlying Cause (Disaasa or Injury	Lancer of	The	Lung					1	entrop
œ	the the	edical	that initiated evants rasulting in death) Last	Dua to (or as a co	nsequence of):						
×	entific ding p	2		d							į	
9	death ce	lan										
9	y the a	Physician/	Part II. Other significant conditions or	ontributing to death but not ra	suiting in t	ha undarlying c	ausa giver	n in Pert I.	23b. Did to	bacco uss co	ntributs to	the cause of death?
7.	\$ 50 E	P.							PS Y	8 2□ No	3 Prob	ebly 4□Unknown
'n	S 5 8	by										
Records,	v requires been sign should be	Completed							24e. Was e		ava	re eutopsy findings Ilable prior to
S	2 S W	ple									of d	npletion of cause laath?
Ì	0 - 6	Eo							1 🗆 Ya	s 2MNo	10	Yas 2□ No
<u>a</u>	cartificate irector, pag	Be C	25. Was case rafarred to medical					26. Place of De	ath (Check only on	a)		
or Vital	5 00	ToE	axaminar? 1 ☐ Yas 🎉 No	Hospital: Impatlant 2] ER/Outr	atient 3 DC	Other		lome 5 ☐ Resida		ar (Specify)
	는 부 교		27. Mannar of Deeth	28a. Data of Injury (Month, Day Year)	28b. Tir		8c. Injury Work		28d. Dascribe ho			
Ö	thending death.	atio	1 Natural 5 Panding 2 Accident invastigation		inj	ury M		as 2 No				
DIVISION	Substitution of the state of Injury - At home, farm, streat, factory, office 28f. Location (Street and Number of Num								er or Aural	Route Number,		
	Hospital	Medical C	29a. Cartifier (Check only one) Check only one) Certifying Phy Certifying Phy Continue Check only one)	ysicien: To the best of my kn niner: On the basis of axamin	owledga, o ation and/	daath occurred a	at tha tima In my opl	, data and place nion, daath occu	a, and dua to the coursed at the time, do	usa(s) and ma	annar as sta	ated. tha cause(s)
	To the within 2 To the compla	Me		and mannar stated.		20-	License	number		od Data siss -	d /Manth "	Day Vosel
	5 × 5 0		29b. Signeture and title of cartifiar	/			. Licansa			d. Date signe		
7			1200 L.V	anal		0	683	557		DEC. 1	2,19	795
	W		30. Nema and addrass of parson who o		m 23a) (T	ype, Print)						21015
	10		DEAN L. VAS.	SAR 104	PLU	MTRE	ER	RD.	BEL 1	AIR M	YD.	21015
	Sta	ite	31. Data filed (Month, DE, Cear) 9	1995 32. Ragistrar's Sign	ature	6.4						

BALTIMORE, MARYLAND 21215-0020

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within. Flours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-bransit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAR		CERTIFIC	CATE OF DE	ATH	REG. NO					
	1. DECEDENT'S NAME (First, Middle, Last JOHN	EDWARD	WOODA	LL	2.	DATE OF DEATH DATE OF DEATH		3. TIME OF DEATH			
	4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE	-			DATE OF BIRTH (Month, Day, Year)	8.1	BIRTHPLACE (State or Foreign Country)			
	218-28-7192	1 🗆 0M 2 🗆 F	63 YRS. M	ONTHS DAYS HOUR	MIN. J	an. 29,		Md.			
	9a. FACILITY NAME (If not institution, give		9	b. CITY, TOWN OR LOC	OF DEATH						
6	11 Church Lane A	pt. 402		Pikesv	ille		DAL	FIMORE			
	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY										
DIRECTOR		altimore		Pikesv			LIMITS? 1 YES 2 NO				
18 I	10e. STREET AND NUMBER			101. ZIP C	300		10g. CITIZEN	OF WHAT COUNTRY?			
FUNERAL	11 Church Lane A			2120				.S.A.			
BY FU	11. MARITAL STATUS 1 Never Married 2 Merried 3 Widowed 4 Divorced	IF YES GIVE WAR OR DATES				13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No— If yea, specify Cuban, Mexican, Puerto Rican, etc.) 1 YES 2 NO Specify: Specify:					
8	15. DECEDENT'S ED (Specify only highest grad	UCATION	16a. DECEDENT'S US	BUAL OCCUPATION	add a se	16b. KIND OF BU	SINESS/INDUST	White			
COMPLETED	Elementary/Secondary (0-12)	College (1-4 or 5+)	life. Do NOT use i	k done during most of wo etired.)	onang						
M M	12		Sales			Public 1	Relatio	ons			
8	17. FATHER'S NAME (First, Middle, Last)			18. W	OTHER'S NAME	(First, Middle, Meiden	Sumame)				
BE	Unknown	Wo	odall		argaret			ight			
2	19e. INFORMANT'S NAME (Type/Print)			DDRESS (Street and Nun				de)			
	Mr. Walter Waltr			olby Rd. I	Baltimo:						
	20a. METHOD OF DISPOSITION \$\(\) Burial 2 \ Cremation 3 \ Re 4 \ Donation 5 \ Other (Specify) \	moval from State	ob. PLACE AND DATE OF emetery, cremetory or othe Parkwood C	DE DISPOSITION (Name of part part part part part part part part							
	nc.										
\vdash	23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate										
NO	shock, or heart failure. List only one cause on each lina. IMMEDIATE CAUSE (Final disease or condition resulting in death) a. ARTERIOSALOROTIC CARDIO VASCULARD, SERVE CARS DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions.										
F	if any, leading to immediate cause. Enter UNDERLYING	00E 10 (011 A2	A CONSEQUENCE OF J.								
CERTIFICATION	CAUSE (Disease or injury that initiated events	DUE TO (OR AS	A CONSEQUENCE OF):								
E	reaulting in death) LAST	d.									
	DAST II Other pignificant condition	and contribution to doubt	h								
EDICAL	PART II. Other aignificant condition	ma contributing to death	but not reaulting in	the underlying caus	le given in Par	rt i. 24a. WAS AN PERFOI		24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE			
ă						1 TYES 2	NO	OF DEATH?			
2						-		1 NES 2 NO			
AN	25. WAS CASE REFERRED TO MEDICAL			26 PLACE O	F DEATH TOhock	ook onel					
PHYSICIAN:	EXAMINERY 1 PES 2 NO	HOSPITAL:		THER:	/						
H	27. MANNER OF DEATH	28e. DATE OF INJURY	Y 28b. TIME	DF 28c, INJURY A		d. DESCRIBE HOW I	NJURY OCCUR	ED			
ВУ Р	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year,) INJUS	M 1 YES	2 🗌 NO						
0	3 Suicide 6 Could not be 4 Homicide determined	28e. PLACE OF INJUI building, atc. (Sp	RY — At home, term, str pec/ly)	set, factory, office	26	Bt. LOCATION (Street City or Town, State)		Rural Route Number,			
1	29e. CERTIFIER 1 CERTIFYING PHY	SICIAN: To the best of my kno	owledge, death occurred	at the time, date and p	ace, and due to t	the cause(s) and ma	nner as stated.				
COMPLET	one) 4EDICAL EXAMI	NER: On the besis of examinat						ouse(s) and manner as stated.			
BE	296. INCHASTORE AND THUE-OF CENTIFI	liamse	mam	7 296	LICENSE NUMBE	7 1	294. DATE SI	1,4/95			
5	30. NAME AND ASSENCES OF PERSON W	THO COMPLETED CAUSE OF	DEATH (ITEM 27) (Type, P	405F	Rado	Riese	ROA	2			
	31. DATE FILED (MONTY Dep year)	3 REGISTRAR	MATURE	1 - 2 - 1		Cas	n /00	1.16E 2/22E			
	ProT 0 1323					-11.1	0 47.0	1, LLE 4228			



FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

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DIVISION OF VITAL RECORDS, P.O. BOX 68760,	
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		1. DECEDENT'S NAME (First, Middle, Last) Julia Ev	a Maria	To 7 4 7 m	o t h			2. DATE OF DEA	DAY	YEAR	TIME OF DEATH
		4. SOCIAL SECURITY NUMBER		E (In yrs. les	t birthday) IF t	UNDER 1 YEAR	IF UNDER 24 HRS.	7 DATE OF BIR	18, 19	S. BIRTHPL	3:15am M
P		212-09-6962	1 M 2 F	81	YRS. MON	THS DAYS	HOURS MIN.	Malan, DIX.7	71914	Mar	vland
3 should	œ	en. FACILITY NAME (If not institution, give Meridian -Fra		35	96.		DR LOCATION OF DI			TY OF DEA	more
2	DIRECTOR	RESIDENCE OF DECEDENT		us		T/ C	JSSVIII	2	B	3.1.6.1	MOLE
Pages		Md. In the state of the state o	altimore		10c. CITY, TO		ation iddle Ri	wor		10	Dd. INSIDE CITY LIMITS?
ermit.		10a. STREET AND NUMBER	alcimore				I COLE KI	rver	10g CITIZ		YES 2 NO
physician. burial-transit permit, Pages 1,	FUNERAL	1212 Susc	uehanna A	ve,				21220		USA	
hysicla urial-tr	P.	11. MARITAL STATUS 1 Never Married 2 Married	R IN U.S. AR		13. WAS DI	ECENDENT OF HISPAI	NIC ORIGIN? (Spec	Ify Yes or No 1	4. RACE — Black, Y	- American Indian, White, etc.	
ding p	BY	3 □₹Widowed 4 □ Divorced	IF YES, GIVE WAR DE	DATES			S 2 ND Specif			Specify:	hite
r atten USE as	ETED	15. DECEDENT'S EDI (Specify only highest grad		(G	CEDENT'S USU	done during i	TIDN nost of working	16b. KIND (F BUSINESS/INDU		11100
spital o	PLE	Elementary/Secondary (0-12)	College (1-4 or 5+)		Do NOT use reli				own h	ome	
detach	COMPL	17. FATHER'S NAME (First, Middle, Last)						ME (First, Middle, A	falden Surname)	JAN C	
ed by	BE (Pietro Del C	astello					ina Co			
24 hours after death. Page 6 may be retained by the hospital or attending physician. filled in by the funeral director, page 5 should be detached for use as the buriat-transion, or removal.	일	19a. INFORMANT'S NAME (Type/Print) John Wilmoth 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1212 Susquehanna Ave. Baltimore Md									
e 6 may be ector, page must be		20a. METHOD OF DISPOSITION SCI Burial 2 Cremation 3 Ren	noval from State	ob. PLACE	ND DATEDF DIS	SPOSITION (Name of ith 12/2	DATE 2	De. LOCATION — CI	ty or Town	, State
Page al direc		4 Donation 5 Other (Specify) 21, SIGNATURE OF FUNERAL SERVICE LI		Gara	ens of		AND ADDRESS OF FA		OSSVII	Te M	!Q •
death. Pag t funeral dir il.		· R. Terr	y (A	Me			nelly Fu MaceAve				
d in by the or removal.		23. PART I. Enter the diseases, or	complications that cause on	sed the de	eth. Do not e	nter the m	ode of dylng, suc	h an cardiac or	reapiratory arre	nt,	Approximate
rted within 24 hou completely filled in fall, cremation, or cremation, or covent, the me		IMMEDIATE CAUSE (Final disease or condition resulting in death)	a. PNEUN DUE TO (DR AS	1001	A						Interval Between Onset and Death Oh P Week
e be executed within sician and completely flor to burial, cremat traumatic event, it	NO	Sequantially list conditions,	b. DUE TO (OR AS	S A CONSEC	UENCE DEL						
ate be hysician prior t	CAT	If any, leading to immediata cause. Enter UNDERLYING CAUSE (Disease or injury	c								
requires that the death certificate be een signed by the attending physician of Health and Mental Hygiene prior shows any injury, or other trau	CERTIFICATION	that initiated events resulting in death) LAST DUE TO (DR AS A CONSEQUENCE OF): d.									
by the att ind Menta / Injury.		PART II. Other significent condition						Part I. 24a. W	AS AN AUTOPSY ERFORMED?		ERE AUTOPSY FINDINGS MILABLE PRIOR TO
uires that the signed by to Health and In	EDICAL	SEVENE BILL	AIERAL	101	124CE	REBI	ZAL	_ 101	ES 2 NO	00	OMPLETION OF CAUSE F DEATH?
VSICIAN: The law requires s certificate has been signed to the State Dept. of Health of, or Item 23 shows and	Σ	FIEMOIQQ-FIGE								1	YES 2 DAG
The land te has ate Dep	SICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	NOSSITAL .				PLACE OF DEATH (Ch	eck only one)			
CLAN: ertifica the Sta or it	IYSI	1 TYES 2 THO 27. MANNER OF DEATH	HOSPITAL:		DOA 4 N		me 5 🗆 Rasiderica	6 Other (Specif	()		
DING PHYS After this o death with	ву рну	1 Natural 5 Pending 2 Accident Investigation	28s. DATE OF INJUR (Month, Day, Year		28b. TIME OF INJURY	W	IJURY AT YORK? YES 2 ND	28d. DESCRIBE I	YOW INJURY OCCU	RED	
OR ATTENDING DIRECTOR: After hours after death item 28 is ma	ETED E	3 Suicide 6 Could not be determined	28s. PLACE OF INJU building, etc. (S)	RY — At hor pecify)	ne, tarm, atreet,	, factory, off	ica .	28t. LOCATION (S City or Town,	Street and Number of State)	Rural Rout	te Number,
4 7 2 H	COMPLE		ICIAN: To the best of my kn								nd manner as stated.
2 MEDICAL EXAMINER: Dn the basis of examination and/or investigation, in my opinion, death occurred at the time, date and piaca, and 2 MEDICAL EXAMINER: Dn the basis of examination and/or investigation, in my opinion, death occurred at the time, date and piaca, and 29b. SIGNATURE AND TITLE OF CERTIFIER 29b. SIGNATURE AND TITLE OF CERTIFIER D 46304											onth, Day, Year)
De de la la la la la la la la la la la la la	TO B	30. NAME AND ADDRESS OF PERSON WIT	O COMPLETED CAUSE OF	_	27) (50- 0)		D463	304	Dec	.emb	rer 19, 1995
		9000 FRANKLIT	u square b				ORE MD	2123)		
		DEC19 1995	JA REGISTRAR'S SK								
											DHMH. 18 Day 1/80

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

State of Maryland / Department of Health and Mental Hygiene 95 Certificate of Death 1. Decadent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month **Physician** WIEGAND Elmer 16, 1995 December 7:36 Pm /Medical 4a. Facility Nama (If not institution, giva straat and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Baltimore Franklin Square Hospital Rossville If Under 1 Year 8. Date of Birth (Mopth, Day, Year) 9. Birthpleca (Steta or) Country 1 3 1920 MARY 1 and 5. Social Security Number 6. Sex If Under 24 Hrs. 7. Aga (In yrs. last birthday) 9. Birthpleca (Steta or Foreign **Funeral** Days Min. Months Hours 100M 20 F 75 217-14-3541 Yrs Director Usuel Residence of Decedent filed within 72 hours after deeth with the Marylend 10a Steta 10c. City, Town or Location 10d. Inside City Limits or 28a-f show the Medical Examiner must be notified at Md. Baltimore Essex 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 932 Homberg Ave. 238 21221 USA Funeral 12. Was Decedeni Ever in U,S. Armed Forces? 1√2 Yas 2 ☐ No If Yas, Giva 13. Wes Decedent of Hispenic Origin? (Specify Yas or No-if Yas, specify Cuban, Mexican, Puerto Rican, etc.) or Herns 14. Race - American Indian, 11. Maritel Stelus Black, While, etc. 1 Never Married 2 Married Saltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: þ Specify: 3 ☐ Widowed 4 ☐ Divorced White Yeer or Detes: natural', Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupetion 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) el Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) 10th Disel Mechanic Beth Steel 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Be 2 should be fit and Mentel F 2 Edward Wiegand Minnie Hubbe 19e. Informant's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s ment of Heelth an of Heelth item 27 I Mary Wiegand 932 Homberg Ave. Baltimore Md.21221 other 20b. Pleca of Disposition (Name of cametery, cremetory or other pleca) 20a. Mathod of Disposition 20c. Location - City or Town, Stata Dale permit. Pages Department of Important: If its any Injury or o 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from State Holly Hill Cemetery12/20/95 4 ☐ Donation 5 ☐ Other (Specify) Balitmore Md. 21. Signatura of Funerel Service Licanses 22. Nama and Addrass of Facility Connelly Funeral Home of Essex 300 Mace Ave. Baltimore MD. 23a. Part1. Entar the diseesa, or complications that caused ha death shock, or heart feilure. Let gray one cause on each line. Approximete Interval Between Onset end Deeth Do not enter the mode of dying, such as cardiec or respiretory arrest, Physician hour Myocardial infarction Immediate Cause (Finel diseasa or condition resulting in death) /Medical Examiner Due to (or es a consequence of): Examiner Arteriosclerotic cardiovascular disease 8 hour The law requires that the death certificate be executed attending physician and for use as the burial-transit Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury Due to (or es e consequence of): Box 68760. Physician/Medical that initieted events resulting in deeth) Lest Due to (or es e consequence of): P.O. Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by t 1X Yes 2 No 3 Probably 4 Unknown Division of Vital Records. by 24e. Was an autopsy 24b. Were autopsy findings Completed available prior to completion of causa of death? performed? hes certificate or Attending Physician: Be 25. Wes case referred to medical 28. Piece of Deeth (Check only one) Hospitel: 1 Inpatient examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 2 ER/Outpatient 3 DOA this 27. Megher of Deeth 28c. Injury et Work? 28b. Time of 28d. Describe how Injury occurred Certification: After t 1 Naturel 2 Accident 5 Pending Investigation s after death.

I Director: All of the fu death. 1 ☐ Yas 2 ☐ No 6 Could not be 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 3 Suicida 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, deeth occurred et the time, deta end piece, end dua to the cause(s) and manner es stated.

2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, dete end piece, end due to the cause(s) end menner steled. Medical 29a. Certifier (Check only one) 29d. Dete signed (Month, Dey, Year) 29b. Signeture and title of cartifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Prini)
Dr Arturo Norico MD. 9000 Franklin Square Drive Baltimore Md 21237

DHMH 16 Rev 6/95

State

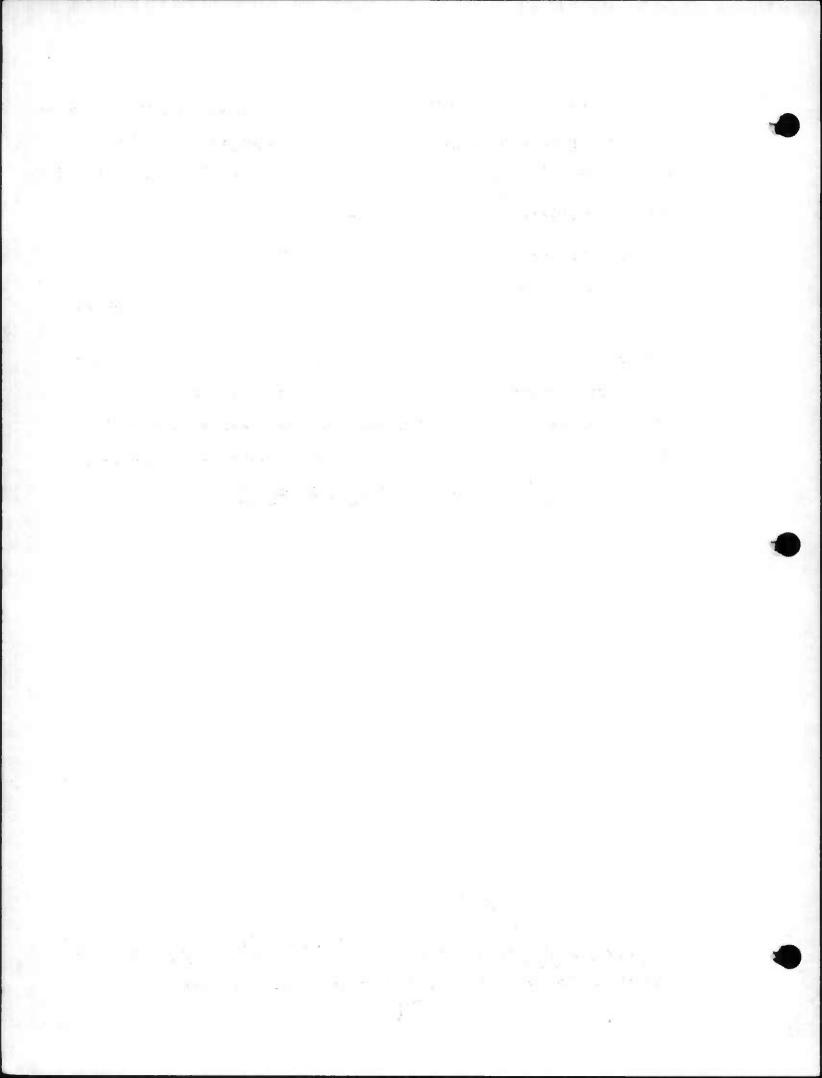
Registrar

31. Dete filed (Month, Dey, Year) UEU 1 9 199.

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32. Registrer's Signeture

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FOR STATE REGISTRAR CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH arv Onred 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birtnday IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign Country) 218-16-2990 HOURS 70 1 M 2 X F YRS. Maryland Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Meridian Nursing Home Towson Baltimore 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Middle River Baltimore Md. permit. 1 YES 2 NO 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 21220 USA 101 Rodeo Circle funeral director, page 5 should be detached for use as the burial-transit retained by the hospital or attending physician. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—
 If yes. specify Cuben, Maxican, Puerto Rican, etc.) 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 TYES 2 THO IF YES, GIVE WAR OR DATES 14. RACE — American Indian, Black, White, etc. If yes, specify Cuben, Maxican, Puerto Rica 1 ☐ YES 2 🔯 NO Specify: 1 Never Married 2 Married BY **\$** Widowed 4 □ Divorced Specify: White 16a. DECEDENT'S USUAL OCCUPATION ETED 15. DECEDENT'S EDUCATION 16b, KIND OF BUSINESS/INDUSTRY (Spi (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) COMPL Housewife own home 8th 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) To Skidmore Oscar Mary Yantz BE notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Balitmore Md. 21220 Debbie Holton 13 Latia Court Page 6 may be 9 20a. METHOD OF DISPOSITION
1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removat from State 20b. PLACE AND DATE OF DISPOSITION (Name of OATE 20c. LOCATION - City or Town, State must cemetery, crematory or other place; 4 Donation 8 Other (Specify) Metro Crematory 12/16/95 baltimore Md. the medical examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY hours after death. Connelly Funeral Home of Essex in and completely filled in by the to burial, cremation, or removal. 300 Mace Ave. Baltimore Md. 21221 23. PART t. Enter the diseases, or complications that caused the de the Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximata shock, or heart limiting. List only one cause on each Interval Betwe IMMEDIATE CAUSE (Final Onset and Death disease or condition_ event, resulting in death) DUE TO (OR AS A CONSEQUENCE O traumatic CERTIFICATION PALLO attending physician and Sequentially list conditions, if any, leading to immediate certificate be prior cause. Entar UNDERLYING CAUSE (Disease or Injury other DUE TO (OR AS A CONSEQUENCE OF): that initisted events resulting in death) LAST 6 the atten Injury, PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE 24a. WAS AN AUTOPSY PERFORMED? MEDICAL Health and that any Masaica 1 TYES 2 NO 1 UYES NO Shows been s DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: has be 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) certificate h item EXAMINER? HOSPITAL QTHER: /NO 1 | Inpatient 2 | ER/Outpatient 3 | DOA ng Home 5 - Residence 8 - Other (Specify) 0 28e. OATE OF INJURY (Month, Day, Year) 27. MANNER OF WEATH 28b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED this (marked. 1 Netural 2 Accident 5 Pending Investigation м 1 YES 2 NO BY After ATTENDING 28a. PLACE OF INJURY — At home, farm, street, factory, offica building, etc. (Specify) 86 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) ETED. DIRECTOR: / 6 Could not be 28 4 Homicide determined Item 8 29a. CERTIFIER COMPL CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and menner se stated. (Check only one) TO THE HOSPITAL
TO THE FUNERAL (
be filed within 72 h
IMPORTANT: If I) HOSPITAL 2 MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) end menner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE 100 77 2 COMPLETED CAUSE OF DEATH (ITEM 27) (Type) Print DEC 1 9 199 32 REGISTRAR'S SIGNATURE Davidson Realall 1995

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

BALTIMORE, MARYLAND 21215-0020	hours after death. Page 6 may be retained by the hospital or attending physician.	s certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should if the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	t, the medical examiner must be notified at once.
DIVISION OF VITAL RECORDS, P.O. BOX 68760	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within To after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the fur be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: it item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	1 - FOR STATE REGISTRAR	E OF MARYL		RTMENT OF H		MENTAL HYGIEN						
	1. DECEDENT'S NAME (First, Middle, Last) Cath	nerine	Anne	Walter	s	2. DATE OF DEATH DEC 16	1995	3. TIME OF DEATH 9:55				
	4. SOCIAL SECURITY NUMBER 181-46-0791 8a. FACILITY NAME (If not institution, give street and nu	² X ^F 4((In yrs. lest birthday) YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) APR 5, 19	8. BIFF Cour	THPLACE (State or Foreign ntry)				
TOR	6052 Tree Swallow				umbia	9c. COUNTY OF	ward					
DIRECTOR	Maryland H	oward	10c. CIT	Y, TOWN OR LOCAT	Colu	mbia	10d, INSIDE CITY LIMITS? 1 52 YES 2 NO					
FUNERAL	6052 Tree Swallow			101	ZIP CODE	044		WHAT COUNTRY?				
B	1 Never Married 2 V Married FORC	DECEDENT EVER IF ES? 1 TYES S, GIVE WAR OR D	2 NO		IIC ORIGIN? (Specify Yen, Puerto Rican, etc.)	Blo	CE — American Indian, ok, White, etc.					
COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College	(1-4 or 5 +)	(Give kind of life. Do NOT u		st of working		SINESS/INDUSTRY	<u>White</u>				
COMF	17. FATHER'S NAME (First, Middle, Last)		Administ	trative A		ME (First, Middle, Maiden	ental (ffice				
BE	Mitchell Pri 19a. INFORMANT'S NAME (Type/Print)	nce	19b. MAILING	ADDRESS (Street a	Joan							
2	Upton J. Walters 6052 Tree Swallow Ct. Columbia, MD 21044											
	206. METHOD OF DISPOSITION 1 Burlel 2 Cremetion 3 Removal from State 4 Donation 5 Other (Specify) 206. PLACE AND DATE OF DISPOSITION (Name of camelety, cremetry or other place) Metro Crematory, Inc. 12/18/95 Baltimo											
	21. SIGNATURE OF FUNCTAL SERVICE LICENSES George E. Mac	with		Crema	tion Sc	ciety of	Md.,					
CERTIFICATION	23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cerdiec or reapiratory arrest, abrock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition reaulting in death) Approximate interval Between Onset and Death Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST Approximate interval Between Onset and Death Approximate											
MEDICAL C	PART II. Other aignificant conditiona contribu	Part I. 24a. WAS AN PERFOR	MED?	b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH? 1 YES 2 NO								
PHYSICIAN:	DID TOBACCO USE CONTRIBUTE 1 25. WAS CASE REFERRED TO MEDICAL		F DEATH YE		UNCERTAIN							
YSIC		TAL: lant 2 - ER/Outp	atlent 3 DOA	OTHER: 4 Nursing Hom	5 Masidence	8 Other (Specify)						
B	1 Netural 5 Pending 2 Accident Investigation	DATE OF INJURY (Month, Day, Year)		IURY WO	RK? ES 2 NO	28d. DEŞCRIBE HOW I						
ETED	4 Homicide determined	building, atc. (Spec	effy)	stroot, factory, offici		28f. LOCATION (Street a City or Town, State)	and Number or Hural	Route Number,				
COMPLETED	29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the b							(a) and manner as stated.				
TO BE	29b. SIGNATURE AND TITLE OF CERTIFUER 30. NAME AND ADDRESS OF PERSON WHO COMPLET	Van E	ATH (ITEM 27) (Trope	20	Day	53 ²	▶ 12/1	B (Month, Day, Year)				
	DEVID & MAN ECH 31. DATE FILED (MONITY, Day, Year) 132 R		USF A	16 Can	ca. Ctr	2750	RENG	St, Bulto				
	(Ja	DOMEST NAME	Roll					DUMAN 40 Don 41				

DHMH-16 Rev 1/89

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be field within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Hem 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

1	FOR STATE	STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL	HYGIENE
1.	REGISTRAR	CERTIFICATE OF DEATH	REG. NO.
Г	A DECEMENTION MANUE (FILE AND AND ADDRESS.		

	REGISTRAN		CE	-NIIII	CATE	UF	DEAL	П	RI	EG. NO.				
i	1. DECEDENT'S NAME (First, Middle, Last) LOUIS HENRY	WITT JR.						2. DATE OF D	DAY		YEAR	3. TIME OF DEATH		
	LOUIS HENRY 4. SOCIAL SECURITY NUMBER	5. SEX				1 YEAR	IF UNDER	24 HRS.	7. DATE OF B	HTE		3:00 P M PLACE (State or Foreign		
Į	214-50-1168	1 🔀 💥 2 🗌 F	45	YRS.	MONTHS	DAYS	HOURS	MIN.	JAN T	8, 1	950		RYLAND	
_	9a. FACILITY NAME (If not institution, give s	A STATE OF			9b. CITY	TOWN (OR LOCATION	ON OF DE	ATH		9c. COUN		EATH	
ET.	THE JOHNS HOPKIN		BA	LTIM	ORE	CITY				n/a				
DIRECTOR	10s. STATE 10b. COUNT	10c. CITY	, TOWN C								10d. INSIDE CITY			
	MD 10+, STREET AND NUMBER			D/		MORE				40 01717		1 TYES 2 NO		
FUNERAL	1232 N.	POTOMAC	STREET			101		2121	3			ITE(
B	11. MARITAL STATUS 1 Never Married XX Married 3 Widowed 4 Divorced	T EVER IN U.S. AR YES 2	MO If yes, specify, Cuban, Mexican, Puerto Rican, etc.;					Black	- American Indian, , White, etc. >:BLACK					
요	15. DECEDENT'S EDU (Specify only highest grade		/G	CEDENT'S	vork done o	CCUPATIO	ON ost of working	10	16b. KINI	OF BUS	INESS/INDU	STRY		
COMPLETED	Elementary/Secondary (0-12) 12 th	life.	life. Do NOT use retired.) LONGSHOREMAN					ST	EAM	SHIP	TRA	ADE		
- 11	17. FATHER'S NAME (First, Middle, Last) LOUIS YEWI					18, MOTHER'S NAME (First, Middle, Melden Sun ETHEL BEANE						iumame)		
O BE	19a. INFORMANT'S NAME (Type/Print)		191	b. MAILING	ADDRESS		nd Number	or Rural F	Route Number, C	ity or Town				
۲	ALBERTA YE	,												
MX Burlei 2 Cremation 3 Removal from State Completely Committee A Donation 6 Other (Specify) RANDALLST(
	21. SIGNATURE OF FUNERAL SERVICE LI	/	land	2			C. M			101	E. N	IORTI	H A VE.	
	23. PART I. Enter the diseases, or shock, or heert failure. IMMEDIATE CAUSE (Finel disease or condition resulting in death)	e. Pulm	t caused the de	ed	em		ode of dy	ing, suci	h as cardiec	or reapir	atory srre	et,	Approximats Interval Between Onset and Death Zdays	
RTIFICATION	Sequentially list conditions, if smy, leading to immediate Due to (or as a consequence of):											3 days		
2	cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events		OR AS A CONSE		j: , ,								-> days	
CERT	resulting in deeth) LAST	a. Aort	ic val	ve	del	1150	61) C	9					4 days	
F1	PART II. Other algnificent condition	ne contributing to	deeth but not r	eeulting i	n the un	derlyin	g ceuse (given in	Part i. 24a	. WAS AN		24b.	WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO	
DICAL	intravenous dr	ug use		hosi	s du	e to	alco	shal	1	YES >			COMPLETION OF CAUSE OF DEATH?	
. ME	DID TOBACCO USE CONT		LISE OF DEA	TH VE	S 🔲 I	NO X	LINIC	ERTAIN					1 TES 2 NO	
AN	25. WAS CASE REFERRED TO MEDICAL			CE OF DEAT			OIAC	EKIAII	, 🗀					
PHYSICIAN:	EXAMINER?	HOSPITAL:	ER/Outpatient 3	□ DOA	OTHER		10 5 🗆 Ri	eldence	6 Other (Sp	ecify)				
BY PHY	27. MANNER OF DEATH Natural 5 Pending	28s. DATE OF (Month, D		26b, TIMI			URY AT ORK? YES 2	NO	28d. DESCRIE	E HOW IN	JURY OCC	URED		
TEO	2 Accident Investigation 3 Suicide 8 Could not be detarmined 28a. PLACE OF INJURY — At home, far building, atc. (Specify)					lory, offic	:0		261. LOCATION		nd Number o	or Rural R	loute Number,	
29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to fhe cause(s) and menor as stated.									d.					
) and menner as stated.					
B	296. SIGNATURE AND TITLE OF CENTIFIE	DV	Hon	1	m		29c. LICI	ENSE NUN	18ER		29d. DATE	SIGNED	(Month, Day, Year)	
임	30. NAME AND ADDRESS OF PERSON WH	f 1	SE OF DEATH (ITE	M 27) (Type,	Print)	JEF	FREY	D.	PERKIN	S, M	D. A.	\(\sigma\)	7,770	
	31. DATE FILED (Month, Oay, Year) ULU 91005	1/	AR'S SIGNATURE) N	N) /te	2)1.	/	rsulh,	nore	, 19	0	(128)	
	DEU1 91995	hi Marie	P. I II											



BALTIMORE, MARYLAND 21215-0020	4 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	re medical examiner must be notified at once.
DIVISION OF VITAL RECORDS, P.O. BOX 68760	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the fun- be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

It	eml,Film730,12/18/95,1t	<u>.</u>					95	38315					
	FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPAR CERTIFI	IMENT OF	HEALTH AND F DEATH	MENTAL HYGIEI							
	1. DECEDENT'S NAME (First, Middle, Leet) NORINO	JOHN	ZORZ	п		2. DATE OF DEATH	1995	YEAR 3. TIME OF DEATH 10:20 ATT					
	4. SOCIAL SECURITY NUMBER		(In yrs. lest birthday)	IF UNDER 1 YEAR		7. DATE OF BIRTN	1000	B. BIRTNPLACE (State or Foreign					
	365-36-2172 9a. FACILITY NAME (If not institution, give at	1 💢 M 2 🗆 F	67 YRS.	MONTHS DAYS			1928	Canada					
DIRECTOR	Saint Joseph Medic				or Location of Dison, Mary		Itimore						
E	10a. STATE 10b. COUNTY		10c. CITY	, TOWN OR LO	CATION			10d. INSIDE CITY LIMITS?					
ER	1514 Greenspring Drive 21093 United Sta												
A	11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 1 Never Married 11. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No- Black, 1 Never Married 12. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No- Black, 13. WAS DECENDENT OF HISPANIC ORIGIN?, Specify Yee or No- Black, 14. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No- Black, 15. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No- Black, 16. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No- Black, 17. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No- Black, 18. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No- Black, 19. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No- Black, 19. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No- Black, 19. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No- Black, 19. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No- Black, 19. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No- Black, 19. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No- Black, 19. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No- Black, 19. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No- Black, 19. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No- Black, 19. WAS DECENDENT OR HISPANIC ORIGIN? (Specify Yee or No- Black, 19. WAS DECENDENT OR HISPANIC ORIGIN? (Specify Yee or No- Black, 19. WAS DECENDENT OR HISPANIC ORIGIN? (Specify Yee or No- Black, 19. WAS DECENDENT OR HISPANIC ORIGIN? (Specify Yee or No- Black, 19. WAS DECENDENT OR HISPANIC ORIGIN? (Specify Yee or No- Black, 19. WAS DECENDENT OR HISPANIC ORIGIN? (Specify Yee or No- Black, 19. WAS DECENDENT OR HISPANIC ORIGIN? (Specify Yee or No- Black, 19. WAS DECENDENT OR HISPANIC ORIGIN? (Specify Yee or No- Black, 19. WAS DECENDENT OR HISPANIC ORIGIN? (Specify Yee or No- Black, 19. WAS DECENDENT OR HISPANIC ORIGIN? (Specify Yee or No- Black, 19. WAS DECENDENT OR HISPANIC ORIGIN? (Specify Yee or No- Black, 19. WAS DECENDENT OR HISPANIC ORIGIN? (Specify Yee or No- Black, 19. WAS DECENDENT OR HISPANIC OR HISPANIC OR HISPANIC OR HISPANIC OR HISPA												
9	15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY												
MPLE	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Sales Manager Steel 17. FATHER'S NAME (First, Middle, Last) II. MOTHER'S NAME (First, Middle, Meiden Surname)												
	Marcello Zorzit Gecelia Tresavante												
2	Mr. John Zorzit 190. MAILING ADDRESS (Street end Number or Rural Route Number, City or Town, State, Zip Code) 20809 Slab Bridge Road Freeland, Md. 21053												
	20a. METHOD OF DISPOSITION 1 General 2 Gromation 3 Remote 4 Donation 5 Other (Specify)	tombment Du	PLACE AND DATE OF OTHER PROPERTY OF OTHER PROPERTY PARTY.	F DISPOSITION /	Name of	04TE 200 L	OCATION C	Hy or Town, State n, Maryland					
	21. SIGNATURE OF FUNERAL SERVICE LICE Marke To 1	Rounder T.	Zavoyna	Leo	nard J. R	Ruck, Inc.							
	23. PART I. Enter the diseases, or c	complications that caused List only one cause on e	the deeth. Do no	ot anter the n	node of dying, suc	Road Ba	iratory srre	re, Md. 21214					
	IMMEDIATE CAUSE (Finel disease or condition resulting in death)	LYMPHOCYT		OMA				interval Between Onset and Death					
	resorting in country	DUE TO (OR AS A	CONSEQUENCE OF	:									
ATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING	DUE TO (OR AS A	CONSEQUENCE OF)	:									
RTIFICATION	CAUSE (Disease or Injury that initiated events resulting in death) LAST	DUE TO (OR AS A	CONSEQUENCE OF)	:									
8	PART ii. Other significant conditions	c contribution to doct b											
PHYSICIAN: MEDICAL	- Significant Condition	s continuiting to death b	ut not resulting in	the underlyi	ng couse given in	Part I. 24a. WAS AN PERFO	RMED?	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?					
Σ Σ	DID TOBACCO USE CONTR	RIBUTE TO CAUSE O	F DEATH YES		UNCERTAIN	V 57		1 TYES 2/ NO					
CIAI	25. WAS CASE REFERRED TO MEDICAL EXAMINER?		26. PLACE OF DEATH	(Check only on									
IYSI	1 TYES 2 THO 27. MANNER OF DEATN	1 Ninpetient 2 ER/Outp	etlent 3 🗆 DOA		me 5 🗆 Residence								
ВУ РН	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	28b. TIME INJU	RY V	VJURY AT VORK? YES: 2 NO	28d. DESCRIBE HOW	INJURY OCCL	JRED					
B	3 Suicide 6 Could not be 4 Homicide determined	28e. PLACE OF INJURY building, etc. (Spec	At home, farm, str	eet, factory, off	lca	281. LOCATION (Street City or Town, State)	end Number o	r Rural Route Number,					
COMPLET		CIAN: To the bast of my knowl R: On the basis of examination						d. ceuse(e) and manner es stated.					
E CC	29b. SIGNATURE AND TITLE OF CERTIFIER			, , , , , , , , ,	29c. LICENSE NUN								
TO BE	10/91												

WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
ARINO M.D., 7620 YORK RD., TOWSON, MARYLAND 21204



30. NAME AND

ANTHONY H. GUARINO M.D.,
31. DATE FILED (Month, Day, Year)

DEC1 91905

32. REGISTRAN

32. REGISTRAR'S SIGNATURE

_Mio.

BALTIMORE, MARYLAND 21215-0020	hours after death. Page 6 may be retained by the hospital or attending physician.	FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.	medical examiner must be notified at once.
DIVISION OF VITAL RECORDS, P.O. BOX 68760	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once,

											95	3	8311	5
	1 - FOR STATE REGISTRAR	STATE OF M		DEPAR						HYGIEN REG. NO.				
	1. DECEDENT'S NAME (First, Middle, Last) JOHNNIE W. BLACK	(ER							2. DATE OF	DEATH	AV.	YEAR	3. TIME OF DE 4:18 A	
	4. SOCIAL SECURITY NUMBER		6. AGE (In yrs. les	t birthday)	IF UNDER	1 YEAR	IF UNDER	24 HRS.	DECEM		1/, 1		PLACE (State or	
	424-05-5030	1 🗌 M 2 💢 F	74	YRS.	MONTHS	DAYS	HOURS	MIN.	JUNE	lay, Ybar)	21	Countr	BAMA	roreign
TOR	98. FACILITY NAME (If not institution, give at 2508 LAKEVIEW AV	,					R LOCATION				9c. COU	LTIM		
DIRECTOR	10e. STATE 10b. COUNT	Y CIMORE		10c. CITY	r, town o	GEME			-				10d. INSIDE CIT LIMITS?	TY F NO
FUNERAL	100. STREET AND NUMBER 2508 LAKEVIEW AVE	NUE		101. ZIP CODE 21219							U.S.	HAT COUNTRY?		
В	11. MARITAL STATUS 1 Never Merried 2 Married 3 Wildowed 4 Divorced	FORCES? 1	. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☑ NO If YES, GIVE WAR OR DATES 13. WAS DECENDENT O If YES, apecity Cubar 1 ☐ YES 2 ☑ NO						NT OF HISPANIC ORIGIN? (Specify Yes or No— Cuben, Mexican, Puerto Rican, etc.) 14. RACE— Black, Specify:					dlen,
COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 TH GRADE 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) PHARMACY BOOKKEEPER											DUSTRY		-
BE CON	17. FATHER'S NAME (First, Middle, Lest) THOMAS WARREN						EF	FIE	ME (First, Mid MILAM		,			
10	190. INFORMANT'S NAME (Type/Print) CAROLYN GILLUM 2508 LAKEVIEW AVENUE — BALTIMORE, MD 21219 200. METHOD OF DISPOSITION													
	20b. METHOD OF DISPOSITION 1 Burlel 2 Cremation 3 X.Removal from State 4 Donation 5 Other (Specify) MIAMI MEMORIAL PARK 21. SIGNATURE OF FUNERAL SERVICE LIBETISEE 20b. PLACE AND DATE OF DISPOSITION (Name of cometery, crematory of other place) MIAMI MEMORIAL PARK MIAMI, FLORIDA 21. SIGNATURE OF FUNERAL SERVICE LIBETISEE 22c. LOCATION — City or Town, State MIAMI, FLORIDA 22. NAME AND ADDRESS OF FACILITY HUBBARD FUNERAL HOME INC.													
	Hours E. 2	mite			41	07 W	ILKE	NS A	AVENUE	-BAL	CIMOR		D 2122	29
	23. PART I. Enter the diseases, or complications that ceused the deeth. Do not anter the mode of dying, such as cardiec or respiratory arrest, interval Between disease or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions.												Between	
RTIFICATION	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury	DUE TO (C	OR AS A CONSECUTOR AS A CONSEC	OUENCE OF):	C	OPP	3.(02 1	epei	Nev	d)		
CERTI	that initieted events resulting in death) LAST	d		TOLLICE OF	,									
MEDICAL	PART II. Other algorificent condition	eco abo		eauiting li	n the un	derlying	ceuse g	iven in		PERFOR	MED?	24b.	WERE AUTOPSY I AVAILABLE PRIOR COMPLETION OF	OT P
: MED	DID TOBACCO USE CONTI	DIRLITE TO CALL	SE OF DEA	TU VE	S EZ N	10.17	UNC	ERTAIN	_	1E5 2	L3M0		OF DEATH?	NO
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?			E OF DEAT	H (Check o	only one)	UNC	EKIAIN	<u>ч П Г</u>					
YSI	1 TYES 2 NO	HOSPITAL:		□ DOA	OTHER		5 TRe	sidence	6 Other (S	pecify)				
ВУ РН	27. MANNER OF DEATH 1 Netural 5 Pending 2 Accident Investigation		28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY WORK? 1 YES 2					NO NO	28d. DESCR	BE HOW IN	JURY OCC	URED		
ED	3 Suicide 8 Could not be determined	28e. PLACE OF building, at	INJURY — At hore. (Specify)	ne, farm, st	treet, facto	ory, office			261. LOCATIO	ON (Street a own, State)	nd Number	or Rural A	oute Number,	
COMPLET	29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(e) and manner as stated. 2 MEDICAL EXAMINER: On the best of my knowledge, death occurred at the time, data and place, and due to the cause(e) and manner as stated.													
BE CO	29b. SIGNATURE AND TITLE OF CERTIFIER		(29c. LICE	NSE NUM					Month, Day, Year,	

8697

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DR. RONALD ATTANASIO -

1012 NORTHPOINT ROAD - BALTIMORE, MD 21224

31. DATE FILED (Morith, Day, Year)
DEC 2 0 1995

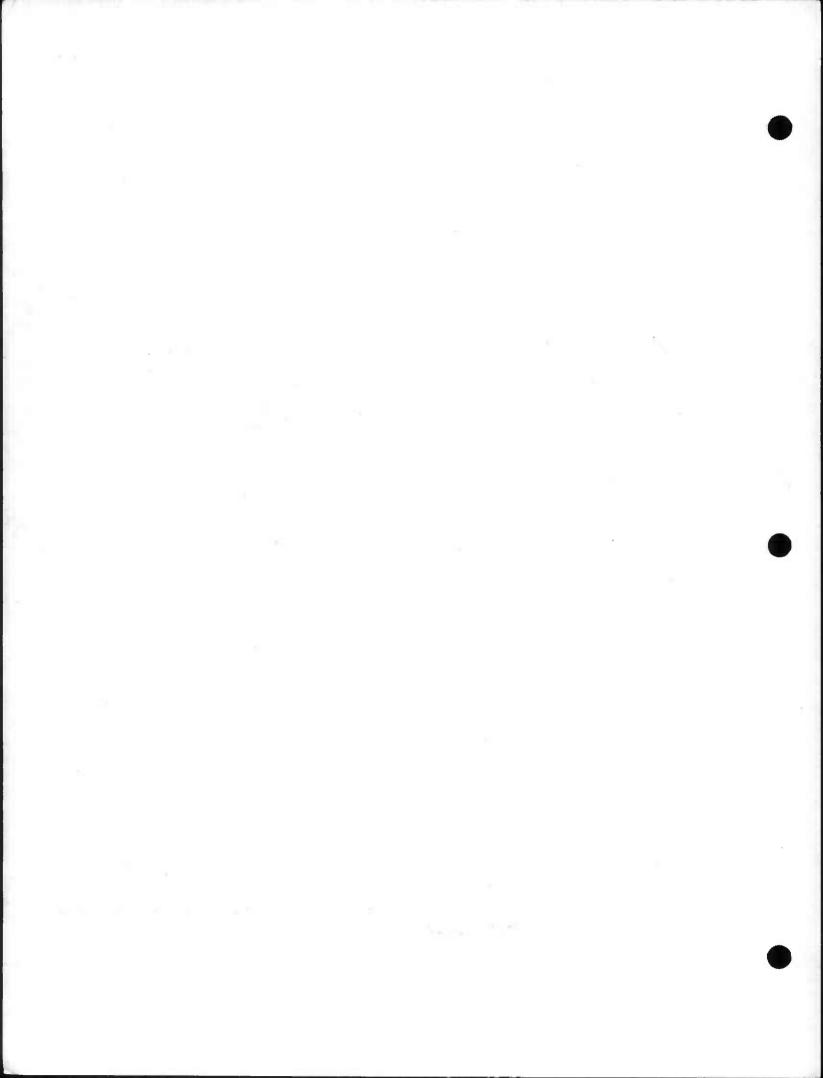


FOR

95 STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

1				ERTIFI					NO.			
	1. DECEDENT'S NAME (First, Middle, Last)							2. DATE OF DEAT			YEAR	3. TIME OF OEATH
	CLARENCE	EARL			B	ROWN	1	ECEMBE		.10	95	8:24 PM
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. I	est birthday)	IF UNDER 1 YE	R IF UNDER 24	HRS.	7. DATE OF BIRT	Н			PLACE (State or Foreign
ì	212-36-8115	1 🔀 M 2 🗆 F	57	YRS.	MONTHS DAT	'S HOURE	MIN.	(Month, Day, Ye Feb. 23	3, 19	938	West	Virginia
	9a. FACILITY NAME (If not institution, give s FRANKLIN SQUAR)		AL		96. CITY, TOY ESS	N OR LOCATION	OF DE		9	c. COUN	ITY OF D	
	RESIDENCE OF DECEDENT											
	Maryland Ba	altimore		10c. CITY	Essex							10d. INSIDE CITY LIMITS? 1 X YES 2 NO
	100. STREET AND NUMBER 212B Woodvale Ct.					101. ZIP CODE 212	221		:10	ZEN OF V	YHAT COUNTRY?	
	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 X Divorced	IF YES, GIVE W	YES 2	NO	If yes	, specify Cuban,		IC ORIGIN? (Speci n, Puerto Rican, et		No-	14. RACE Black Speci	E — American Indian, k, Whita, etc.
DI L	15. DECEDENT'S EOU (Specify only highest grade	CATION completed)	16a. C	16e. OECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)				16b. KIND O	F BUSINE	E9S/IND	USTRY	
CINTER	Elementary/Secondary (0-12) Unknown	College (1-4 or 5 +	<u>'</u>	Coo	k				esta		nt	
1	Russell Brown 19a. INFORMANT'S NAME (Type/Print)							-				
2	Katherine Bociar	,	1					Baltimon				06
	20a. METHOD OF DISPOSITION	1	205 01 40								212	wn, Stata
	1 X Burlat 2 Cremation 3 Ram	novel from State	cemetery.c	remetory or of	her place)	(Name of Co	_					
	4 Donation 6 Dother (Specify) Garrison Forest Veterans 12/12 Owings Mills, 21. SIGNATURE OF JUNERAL SERVICE LICENSES											LS, MD
	D 18 14	(10,0	1992					ERAL HO				
-	23. PAST I. Enter the diseases, or	CCC	7		<u> 600</u>	9 Harfo	ord	Rd., Ba	ltim	ore	, MD	21214
	ahock, or heart fellure. IMMEDIATE CAUSE (Finel disease or condition resulting in death)	a. DUE TO	e on each li	DEOUENCE OF	njug	121						Interval Batween Onset and Death
Entitle Icalifor	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. OUE TO (OR AS A CONSEQUENCE OF): C. OUE TO (OR AS A CONSEQUENCE OF):											
	PART II. Other algnificent condition	ne contributing to	deeth but not	t resulting i	n the under	lying ceuse gi	ven In		AS AN AU		24b	. WERE AUTOPSY FINDINGS
								1/	ERFORME ES 2 🗌			AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
	DID TOBACCO USE CONT	RIBLITE TO CA	LISE OF DE	ATH YE	S D NO	☐ UNCE	PTAIR	<u>"</u> " '				1 YES 2 NO
	25. WAS CASE REFERRED TO MEDICAL	I I I CA			TH (Check only		.KIAII	4 🗆 📗				
2	EXAMINER? 1 X YES 2 NO	HOSPITAL:	Z ER/Outpatient	3 [] DOA	OTHER:	Home 5 🗆 Basi	Idagea	8 Other (Specif				
THI SICIAN.	27. MANNER OF DEATH	28e. DATE OF	INJURY	28b. TIM	E OF 280	INJURY AT	-derice	28d. DESCRIBE	-	JRY OC	CURED	/
- 1	1 Neturel 5 Pending	/2/2/	9 (T	195	OM 1	WORK?	NO	Subjec	1 500	cy C	Sist	Struck
9	2 Accident Investigation 3 Suicida 6 Could not be	28a. PLACE O	F INJURY — At	homa, farm, s	street, factory,	office		281. LOCATION (S		Number	or Rurai	Route Number,
building, aic. (Specify) City or Town, State) 182 (Eastern Duly)												
building, aic. (Specify) 4 Homicide 6 Could not be detarmined 6 Could not be detarmined City or Town, State) 8 Could not be detarmined City or Town, State) 8 Could not be detarmined City or Town, State) 8 City or Town, State)												
1	29b. SIGNATURE AND TITLE OF CERTIFIE	U. T. a	1. 1.	λ		29c. LICEN		ABER				(Month, Day, Year)
2	30. NAME AND ADDRESS OF PERSON WI	HO COMPLETED CAU	SE OF DEATH (IT	TEM 27) (Type,	Print)		J . I		4.		11	. 0,2000
	31. DATE FILE (12 11) 1995		RIS SATURE		enn S	treet,	Ва	altimoı	ce,	Ma	ryla	and 21201

1-UA

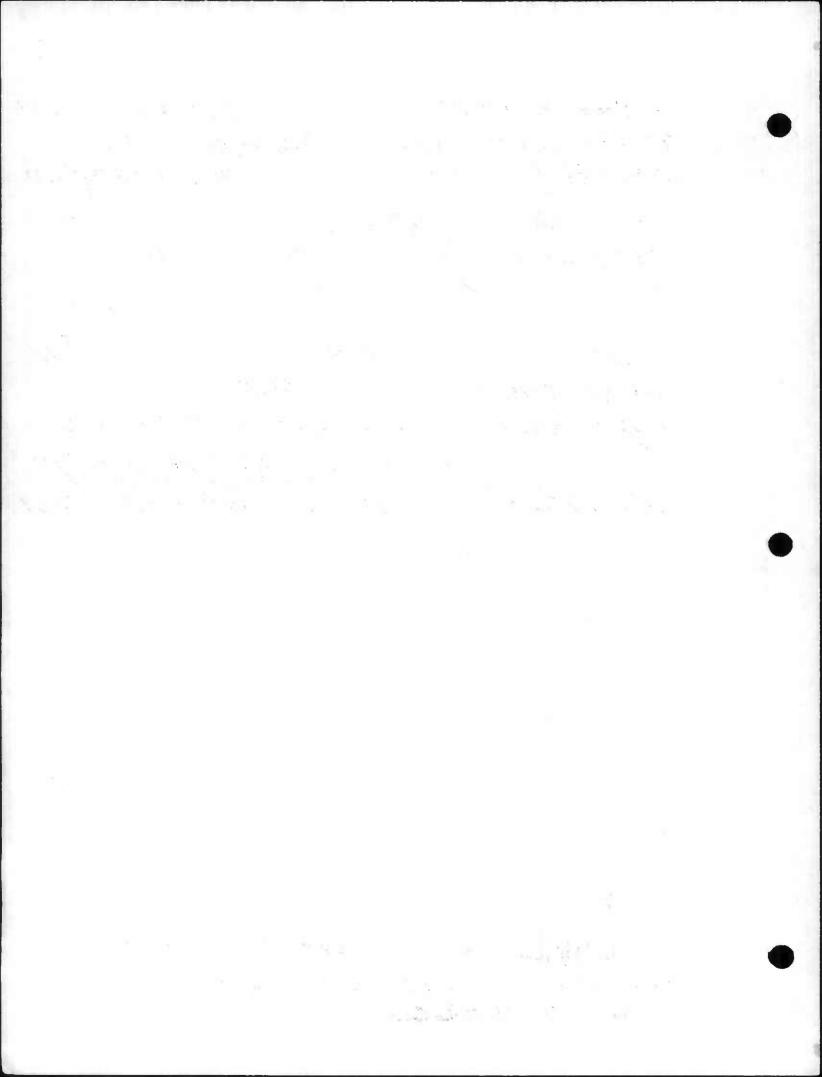


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 95 383 | 8

					Certifica	ate of Death	R	eg. No.	
	Physic /Medi		1. Decedent's Neme (First, Middle, Last	, BARNE	Ŝ		2. Dete of Deet Month		3. Time of Death 9:55 PM
	Exami: Funeral		4e. Fecility Neme (If not institution, give 2201 PROOK) 5. Sociel Security Number 6. Se	FIELD AL	/E 2	4b. City, Town, or PA 17	MORE	4c. County of	9. Birthplece (State or Foreign
L	Director			3M 2DF 111	Yrs. Month	s Deys Hours Min.	8. Dete of Birth (Month, Dey,	1951	MARYLAND
	r 28a-f show	ctor	10a. Stete 10b. County	10c. City	BALTIME	ORE			10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	eth with the 234 or 2	Funeral Director	220 Paranki	FELD AV	E,	21217		og. Citizen of Wh	7
020	filed within 72 hours efter deeth with the Meryland thygiene. ther than "natural", or flems 23a or 28a-f show ont, the Medical Examiner must be notified as	þ	11. Merital Stetus 1 Naver Married 2 Merried 3 Widowed 4 Divorced	12. Wes Decedent Ever in U, Armed Forces? 1 ☐ Yes 2 M No if Yes, Give Yeer or Detes:	If Yes, s	edent of Hispenic Origin? (Specify Cuban, Mexican, Puer 2 No Specify:	pecify Yes or No- lo Rican, etc.)		- American Indian, , White, etc. BLACK
215-0	in 72 hours n "natural",	Completed	15. Decedent's Edu (Specify only highest grad	e completed)	16e. Decedent's Us (Give kind of s life. DQ NOT	vork done during most of wo	rking	16b. Kind of Busi	ness/Industry
d 212	filed withir Hygiene. other than	Com	17. Fether's Neme (First, Middle, Last)	College (1-4or 5+)	LA	WRER 18 Mother's Ne	me (First, Middle, M	LaN9/	ruchon
Maryland 21215-0020	8 ta 5 9	To Be	William B	ARNES	_	MAY	1251	8521	2
	s 1 and 2 should if Health and Mer them 27 is marks other traumatic		19e. informant's Neme/Reletionship (Ty	NGON	2633	ss (Street end Number of Ri	AVE BA	City or Town, St	tate, Zip Code)
Baltimore,	Peges nent of ant: If It ury or o		20e. Method of Disposition 1 Burial 2 Cremation 3 F 4 Donetton 5 Other (Specify)		lece of Disposition (Nemetery, crematory of		12/95 L	ANSDOU	UNE MD,
Balt	permit. Peg Department Important: I any injury o		21, Signature of Funeral Service License	when the same of t	22 Maria GAR	D FIRST THE CE	FUNER	al Hon	15 P.A
la la	Physician		23a. Part Enter the disease, or complished, or heart failure. List only or	cations that caused the death re cause on each line.	n. Do not enter the m	ode of dying, such as cardia	or respiratory arm	HST,	Approximate Interval Between Onset and Death
1	/Medical Examiner		imm diffe Ceusa (Final disease or condition resulting in deeth)	Mycoba	CLPSIAM	ANIUM INF	ECTION		142
	D ==	iner		ADV AVE FC	res e consequance d	" INFECTION			10 485
, 0,	be executed ician end buriel-transit	i Examiner	Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or	r as e consequence o	f):			
ox 68760,	artificate ing phys e as the	√Medicai	that initiated events resulting in deeth) Lest		es e consequence o):			
). Box	that the deeth ce ed by the ettendii detached for use	Physician/	Part II. Other significant conditions con	tributing to deeth but not resu	ulting in the underlying	cause given in Pert I.	23b. Dld to	bacco use conti	ribute to the cause of death?
s, P.O	es that the igned by t be detach		PERI-REGIAL	2 24)28A			1 🗆 Y	2 No 3	3 ☐ Probably 4 ☐ Unknown
Division of Vital Records,	> 0	Completed by					24a. Wes en	n autopsy ned?	24b. Were autopsy findings avallable prior to completion of cause of death?
tal R	ilclan: The iev certificate has rector, page 2		25. Wes case referred to medical			OC Plane of De	1□ Ye		1□ Yes 2No
of Vi	Physician: this certific ral director,	To Be	exeminer?		ER/Outpatient 3	Othory	lome 5 Reside	e/ enca 6 □Other	(Specify)
sion o	To the Hospital or Attending Phys within 24 hours effer death. To the Funersi Director: Affer this completely filled in by the funeral di	Certification:	27. Mannar of Death 1 Neturel 5 Pending investigation 2 Accident	28a. Date of injury (Month, Day Year)	28b. Time of Injury M	28c. injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe ho	w injury occurred	or a column
Divi	taf or Att	Certifi	3 Sulcide 6 Could not be determined	28e. Plece of Injury - At ho building, etc. (Specify	me, ferm, street, fect	ory, offica	28f. Location (St. City or Town		or Rural Route Number,
	n 24 hou n Euner e Funer bletely fill	edicai	29a. Certifier (Check only one) Certifying Physical Certifying Physical Examination (Check only one)	ician: To the best of my knowner: On the basis of exeminet end menner steted.	wledge, death occurre lon end/or invastigation	of et the time, dete and pleca on, in my opinion, deeth occu	, end due to the ce rred at the time, de	use(s) end manr ete end plece, an	ner as steted. id due to tha cause(s)
	Vithii To th	M	29b. Signeture end titla of position	445	2	9c. License number	29	9d. Date signed ((Month, Dey, Year)
			30. Nama and eddress of person who co	mpleted causa of daath (Item				111	-
		40	DAVI D WHECKING			- RM 226 B	400mrs.	WD SI	1501
	Sta Registr	te ar	31. Dete filed (Month, Day, Yar) 1995	Registrer's Signet	Radall				

DHMH 16 Rev 6/95



	DING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after anth Part in the retained by the hospital or attending physician.	this certificate has been signed by the attending physician and completely filled in by the invest direct mage 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should with the State Dept. of Health and Mental Hyglene prior to burial, cremation, or removal.	ed, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at onco.
-	0 0	1	er mus
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	's after d	his certificate has been signed by the attending physician and completely filled in by the inversit die with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	dical ex
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	CIAN: 1	ortificat he Stal	or Ite
	PHYSIC		rked.
	NDING	R: After	is ma
	HE HOSPITAL OR ATTENDIN	THE FUNERAL DIRECTOR: After filed within 72 hours after death	item 28 is market
	TAL OF	3AL DIE	H ite
	HOSP	HE FUNERAL ed within 72 h	APORTANT: II I
	O THE	THE OF MIND	MPOF

FilmG. 730, item #1, 12/20/95,cyw, per f.h. STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	1 - FOR STATE REGISTRAR	STATE OF MARYLA	ND / DEPARTM CERTIFICA			MENTAL	HYGIENE REG. NO.						
	1. DECEDENT'S NAME (First, Middle, Last)		M. COOI	PER		2. DATE O	DE DEATH DAY	15 4	5 3	5 45 pm			
	4. SOCIAL SECURITY NUMBER 212-28-2182D	1 - M 2 PF 6	6 YRS. MON	UNDER 1 YEAR	IF UNDER 24 HRS. HOURS MIN.	//	F BIRTH Day Mear)	1009	Md	ACE (State or Foreign			
TOR	98. FACILITY NAME (If not institution, give street of the				TIMG/			9c. COUNTY		тн			
DIRECTOR	Md Balt	cimore		10c. CITY, TOWN OR LOCATION Dundalk					10d. 1 🖎				
ERAL	100. STREET AND NUMBER 91 Dundalk Aver	nue		101. ZIP CODE 21222					10g. CITIZEN OF WHAT COUNTRY? USA				
BY FUNERAL	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR DA	If yes, spe	ENDENT OF HISPAI ecify Cuban, Maxica 2 NO Specif	in, Puerto Ri	(Specify Yee can, etc.)	y Yee or No— 14. RACE — American Indi Black, White, etc. Specify: White						
COMPLETED	15, OECEDENT'S EQUC/ (Specify only highest grade of Elementary/Secondary (0-12)	ATION completed) College (1-4 or 5+)	(Give kind of work done durin life. Do NOT use retired.)			16b. I	KIND OF BUSI		TRY	.1.00			
12 Homemaker Own Home 17. FATHER'S NAME (First, Middle, Lest) 16. MOTHER'S NAME (First, Middle, Maidle, Surname)													
John M. Todd Clara May Mixter													
198. INFORMANT'S NAME (TyperPrint) Margaret Swanson 198. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15 Dublin Drive, Lutherville, Md. 21093													
Į.	20e. METHOD OF DISPOSITION 1 © Burlel 2 Cremation 3 Removel from State 4 Donation 5 Other (Specify) 20b. PLACE ANOOATE OF DISPOSITION (Name of cametery, crematory or other piece) Garrison Forest Vet C 12/18 Owings Mills, Md												
	22. NAME AND ADDRESS OF FACILITY Bradley Ashton Funeral Home 2134 Willow Spring Road, DundalkMo												
	23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiec or respiratory arrest, shock, or haert feliure. List only one cause on each line. IMMEDIATE CAUSE (Finel disease or condition resulting in desth) S. DELO CARCIJOMA META STATIC DUE TO (OR AS A CONSEQUENCE OF):												
CATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING												
CERTIFICATION	CAUSE (Disease or Injury that Initiated eventa resulting in death) LAST	OUE TO (OR AS A	CONSEQUENCE OF):										
PHYSICIAN: MEDICAL (PART II. Other algorificent conditiona Malnustica	contributing to death bu	it not resulting in th	e underlying	ceuse given in		PERFORM	IED?	AN CC Of	ERE AUTOPSY FINDINGS MILABLE PRIOR TO DMPLETION OF CAUSE F DEATH?			
N. N	DID TOBACCO USE CONTR	BUTE TO CAUSE OF	DEATH YES	□ ON □	UNCERTAIN	V 🗆			1	TYES 2 PINO			
CIA	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	6. PLACE OF DEATH (C	heck only one)									
1YS	1 VES 2 NO	1 Inpatient 2 ER/Outpa		Nursing Home	5 Rasidence								
BY PI	1 Natural 5 Pending	(Month, Day, Year)	INJURY	M 1 Y	RK?	286. OESC	RIBE HOW IN	JURY OCCUR	ED				
										le Number,			
COMPLETED		IAN: To the best of my knowle							tuse(s) si	nd manner as stated.			
BE	29b. SIGNATURE AND TITLE OF CERTIFIER				29c, LICENSE NUN		3			onth, Day, Year)			
5		uphiz 8	H6C 5	205	Hog kin	3	2 24	as Ci	*	le			
	DEC2 1995	32. PEGIŞTRAP'S SIGNA	TURE										

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 95

							Ce	rtificate	of L	Death			Reg. No.			
п	Dhusia	!a=	1. Decedant's Name (Firs	t, Middla, L								2. Data of De	Day	Vaar	3. Tima of Death	
	Physic /Medi		Mary Ca:	rolyn	ı Ca	ampbel	11				Γ	eceml	per 15	1995	7:00pm	
	Exami		4a. Facility Neme (If not h	nstitution, gi	ve street end no	umber)			4	b. City, Town	n, or Loc	ation of Deat	h 4c. County	of Death		
V			Ridgeway	Manc	r Nu	rsing	Home			Balti	Lmor	e	N	/ A		
	Funeral		5. Social Sacurity Number		Sex 1□M 2⊠F	7. Age (In y	rs. lest birthdey)	If Undar 1 \	/aar leys	If Undar 24 Hours	Hrs.	8. Dete of Bi	rth ay, Year)	9. Birthpi	ace (Stata or Foreign try)	
Ь	Director		217-48-60 Usual Rasidenca of Dece	54	IUM ZIĄF	8	6 Yrs.				1	Nov 16,1909 Pa				
	nolym whow		10a. Stete 10b.	County		10c.	City, Town or Lo	cation				10d. tnside City L				
	e Ma	cto	Md F	rede	rick		Woodsb	oro							1 Yas 2 No	
	er er	Dire	10e. Street and Number					10f. Zip Co					10g. Citizan of	What Count	try?	
	ath w 23e	ra	10358 Woo	dsbo:				21	798	3			USA			
5-0020	s 1 and 2 abould be filed within 72 hours after death with the Marylend Health and Mentel Hygiene. Item 27 is marked other than "natural", or items 23s or 28s-f show other traumstic event, the Medical Examinar must be notified a	by Funeral Director	11. Maritei Stetus 1 Nevar Married 2 32 Widowed 4 D	_	Armed F	2√ No live		Wes Deceden f Yas, specify 1 ☐ Yas 2 ☐	Cuba	ispanic Origin, Maxican, i Specify:	n? (Spec Puerto R	cify Yas or No lican, etc.)				
0-10	2 ho	ted	15. C	ecedent's E	ducation		16a, Dece	dant's Usuai C	ccupa	ation			16b. Kind of B			
218	within 7 ene. than "n	Completed	(Specify on: Elemantary/Secondery		ade completad, Collega ((1-4or 5+)	lifa.	kind of work of DO NOT usa i	ona d	during most o	of workin	g				
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Pu	be filed itel Hygid d other event, to	Be	17. Fathar'a Nama (First,	Middla, Las	1)		18. Mothar's Nam					(First, Middle	, Maiden Sumar	ne)		
la	Mentel Merked o	To	Herman F.	Cra	ver					Mar	у В	ertha	Melho	rn		
Maryland	2 ahould and Men le marke aumetic	-	19a. Informant's Name/R	aiationship	(Type, Print)		19b. Maiile	ng Addrass (S	treet s	and Number	or Rurai	Routa Numb	per, City or Town	Stata, Zip	Code)	
	and 2 paith n 27 l		Darlene D	emar	io		103	58 Woo	ods	sboro	Rd	, Woo	dsboro	, Md.	. 21798	
ore	of He		20a. Mathod of Dispositio		70		20b. Placa of Disposition (Nama of cematary, cramatory or other place)					Data	20c. Location	City or To	wn, Stata	
Ĕ	Pages nent of int: If Its		Murial 2 ☐ Cred 4 ☐ Donation 5 ☐ C				orrain	e Parl	k		11	2/18	Baltin	more	, Md.	
Baltimore,	pemit. Pages 1 and 2 Department of Health of Important: if Item 27 It any injury or other tra once.		21. Signatura of Funerel	Service Lice	nsee			. Nama and A							01000	
8	SSEES		Sterling Ashton Funeral Home 21228 736 Edmondson Avenue Baltimore, Md													
x 68760,	eath certificate be executed Exam ettending physician and for use as the burlet-transit	disease or condition rasulting in death) Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):											SCHERE	OAPT)	10 yos	
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P.O.	es that the death cer igned by the ettendin be detached for use	Physician	Part It. Other eignificant				-		-	en in Pert t.					the cause of death?	
	that the ded by detail											1	Yes 2 No	3 Prob	ably 4 Unknow	
of Vital Records,	been s	Completed by										24a. Was	s an autopsy ormed?	ava	ira autopsy findings illabta prior to inpletion of cause death?	
Re	@ <u>-</u> @	mo										10	Yes 210 No		Yes 2 No	
ta	ician: The certificate rector, pag		25. Was case referred to	medical	1					20 Diago	of Dooth	(Check only			2010	
5	Physician: this certific ral director,	o Be	axaminar? 1 ☐ Yas 2 ☑ No	111001001	Hospitel:	Inpatiant 2	□ ER/Outpatier	nt 3□ DOA	Othe	or:			idence 8 Oth	ns (Cnacit	4	
of	r this		27. Mannar of Death			of injury			tnjury Work		1	-	how injury occur		"	
0	ding th.	tion	1 Natural 5 ☐	Pending invastigation		nth, Day Year,) Injury	м		k? Yas 2∐ No	0					
Division	f or Attending I after death. Director: After d in by the funer	Certification:		Could not I	20a. Plac	a of Injury - Ai	t home, ferm, str	eat, fectory, o	ffice		2		(Street end Numi wn, Stata)	ber or Rura	Route Number,	
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical Ce	(Check only 2 N	ledical Exa	miner: On tha b			astigation, in	my of	oinion, daath			cause(a) and m, data and place,	and dua to	the cause(a)	
	To To Con	2	29b. Signatura and titla of	cartifiar		a 21				number	1 . 0-		29d. Dete signe	d (Month, L	Day, Year)	
	~		Mo	nea	a By	Ra	-	M.	0.	090	19		(2/	16/	95	
	5		30. Nama and addrass of DL-NIR		K	001M.7	tam 23a) (Type,	Print) Leveu	507	n La						
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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

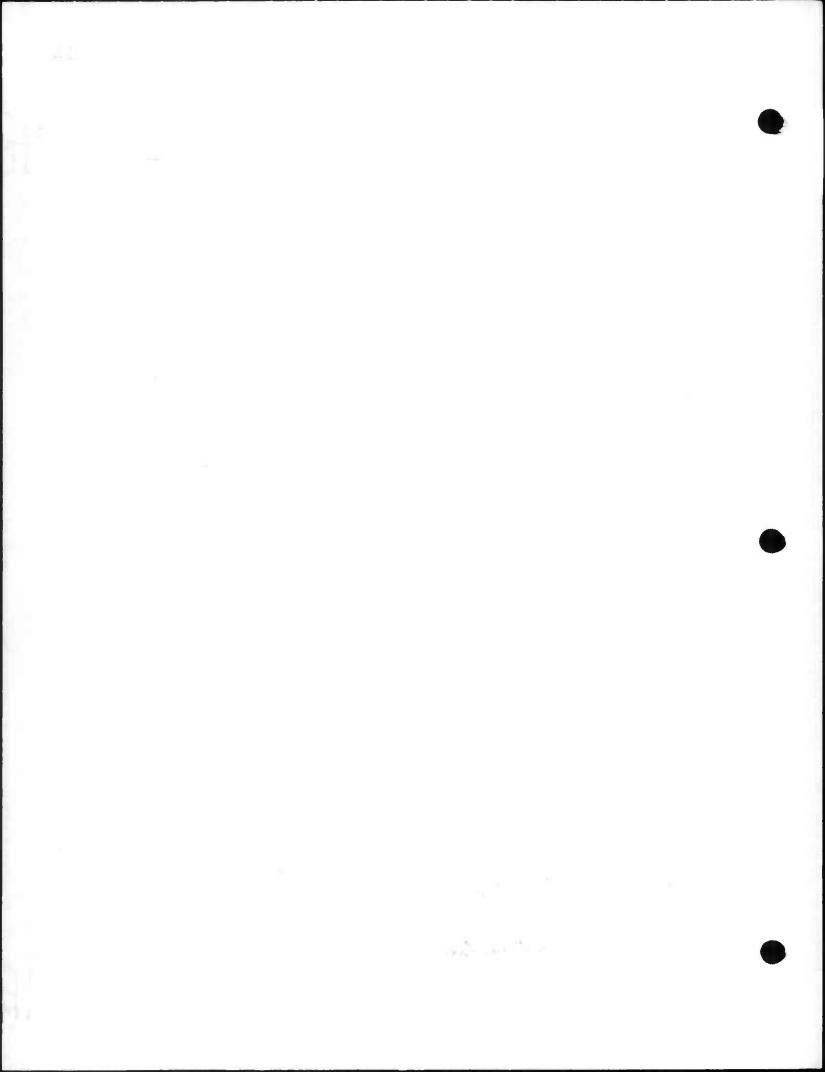
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burlat-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burlat. cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be netified at once.

	FOR 1 - STATE REGISTRAR	STATE OF MARYLAI			HEALTH AND	MENTAL HYGIEN	E					
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH		3. TIME OF DEATH				
	GILBERT	R.	I	ELLA		DECEMBER I	7, 1995	6:09P M				
	THE PART OF THE PART WAS ASSESSED.		yrs. last birthday)	IF UNDER 1 YEAR		7. DATE OF BIRTH	8. BIF	TTHPLACE (State or Foreign				
		M 2 □ F 8	/ YRS.			SEPT. 16						
~	9a. FACILITY NAME (If not institution, give street				N OR LOCATION OF D		9c. COUNTY OF DEATH N/A					
<u>ē</u>	THE JOHNS HOPK	CINS HOSPITA	.L	BAL'	CIMORE CI	TY	N/ A					
DIRECTOR	10e. STATE 10b. COUNTY		10c. CI1	Y, TOWN OR LO				10d. INSIDE CITY				
	MARYLAND	N/A		BAL'	rimore c	CITY		14 YES 2 NO				
FUNERAL	1308 N. WASHINGT	PON CT			101. ZIP CODE 212]	3	10g, CITIZEN O	F WHAT COUNTRY?				
N			I C ADMED	12 140 5								
В	3 Widowed 4 Divorced	WW TIJAN.				· ·		BLACK				
	15. DECEDENT'S EDUCATION (Specify only highest grade com-	ON 1 ipleted)	(Give kind of	Work done during		16b. KIND OF BUS						
ZE.	Elementary/Secondary (0-12) C	college (1-4 or 5+) N/A	ille. Do NOT u	,	700	UNION	TRUST	BANK				
15. DECEDENT'S EDUCATION (Specify only highest grade completed) (Give kind of work done during most of working life. Do NOT use retired.) 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Meiden Surname)												
CHARLES DELLA CORA PROCTOR												
CHARLES DELLA CORA PROCTOR 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) CILADYS DELLA 13.08 N. WASHINGTON CE. BALTO MD 21.21.21												
F	GLADYS DEI	LLA	1308	8 N. W	ASHINGTO	ON ST. BA	LTO, MD	.21213				
	20a. METHOD OF DISPOSITION XIX Buriat 2 ☐ Cremation 3 ☐ Ramovat	from State cemet	ery, crematory or	OF DISPOSITION other place)	DEC.	21,1995	CATION — City or	Town, Stata				
	4 Donatton 5 Other (Specify)	<u>GAR</u>	RISON	FORES	AND ADDRESS OF F	NS CEM (OWINGS	MILLS, MD.				
	150 KV		X			CRUGGS FI	UNERAL	HOME				
_	Carron D'ac	magge	MI.	1141:	2 E. PRE	STON ST	BALTO	MD 21213				
	23. PART I. Enter the diseases, or com shock, or heart fellure. Liet	only one cause on esc	the deeth. Do	not enter the i	node of dying, su	ch aa cardlec or reapi	iratory arres1,	Approximate interval Between				
	immediate cause (Fine) disease or condition resulting in desth) s. Metastatiz alenocarcinena of prostate bue to (or as a consequence or): Oneat and Destr											
	resulting in desth) s	DUE TO (OR AS A C	CONSEQUENCE	DF):	enoma of	prostate		6 months				
z	C 6.											
5	Sequentially list conditions, if any, leading to immediate	DUE TO (OR AS A C	ONSEQUENCE (OF):								
2	CAUSE (Disesse or injury	DUE TO (OR AS A C	CONSEQUENCE O)F)·		_						
CERTIFICATION	that initiated events resulting in death) LAST			. ,								
	d											
AL	PART II. Other significant conditions of	0			ring cause given is	Part i. 24s. WAS AN PERFOR		24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO				
Ö	Squamous cell ca	mer of head	and hee			1 _ YES 2	₩o.	OF DEATH?				
W	DID TOBACCO USE CONTRIB	LITE TO CALISE OF	DEATH V	ES I NO	M UNCERTA			1 YES 2 NO				
PHYSICIAN: MEDIC	25. WAS CASE REFERRED TO MEDICAL			ATH (Check only o								
SIC		OSPITAL: Inpetiant 2 KER/Output	lant 3 🗆 DOA	OTHER:	ome 5 - Raaldence	6 Other (Specify)						
H	27. MANNER OF DEATH	26s. OATE OF INJURY (Month, Day, Year)	26b. TII	WE OF 28c.	INJURY AT WORK?	26d. DESCRIBE HOW I	NJURY OCCURED	,				
BY	1 Netural 5 Pending 2 Accident investigation			M 1	YES 2 NO							
	3 Suicide 6 Could not be	26a. PLACE OF INJURY - building, atc. (Specif)		atree1, factory, o	ffica	281, LOCATION (Street City or Town, State)	end Number or Ru	ral Route Number,				
COMPLETED	no certifier											
MP	(Check only 1 St CERTIFTING PHYSICIAL	N: To the best of my knowled On the beals of examination						andah and announce and added				
	29b. SIGNATURE AND TITLE OF CERTIFIER	AT THE DEGLE OF GASTIMISCHOTT	and/or investigat	on, in my opinio								
BE	Solar Centries				29c. LICENSE NU D353		29d, DATE SIGN	NED (Month, Day, Year)				
2	30. NAME AND ADDRESS OF PERSON WHO C	OMPLETED CAUSE OF DEAT	TH (ITEM 27) (Typ	e, Print)	1 22/3	ران	1-/1	7773				
	Baltimore VA Med	ical Center		reene S	Freet Bal	timore, Md	2120/					
	DEC 2 0 1995	32. REGISTRAR'S SIGNAT				,						

BALTIMORE, MARYLAND 21215-0020	attending physician.
AND 21	the hospital or attendil
MARY	be retained by the ho
IMORE,	leath. Page 6 may be
BALT	urs after death.
09	executed within 24 hou
X 68760	executed

	_	1 - FOR STATE REGISTRAR	STATE OF M	IARYLAND C	DEPAI ERTIF	RTMENT	OF H	EALTH DEAT	AND M		YGIENE REG. NO.			
		1. DECEDENT'S NAME (First, Middle, Last ULYSSES	Dt	JBOSE,						2. DATE OF MONTH	17	P	97	1735 A
should		4. SOCIAL SECURITY NUMBER 248-16-8609 90. FACILITY NAME (If not institution, give	5. SEX 1 M 2 F	6. AGE (In yrs. le	st birthday) YRS.	MONTHS NO.	DAYS	HOURS OF LOCATION		OCT.	11,	190	t S	OUTH CAR
1, 2, 3	DIRECTOR	STELLA MARIS	HOSPICE			Ju. C. 11.		SON	ON OF DEA			9c. COUNTY		0. CO.
permit. Pages		MARYLAND 100. STREET AND NUMBER	N/A		10c. CIT	TY, TOWH O	BAL	TIMO		CITY			1	10d. INSIDE CITY LIMITS? 1 XYES 2 NO
ışı	UNERAL	4619 FURLEY A	VE .			T		212(06			U.S	5.A	
9 9	BY F	1 Never Married 2 Married 3 Wildowed 4 Divorced	FORCES? 1	YES 2	NO	,	f yes, spe	ENDENT O scify Cubar 2 Z-NO	n, Mexican,	ORIGIN? (S Puerto Ricar	pecify Yee a n, etc.)	or No- 14		- American Indian, White, etc. BLACK
27 al or for u	PLETED	15. DECEDENT'S ED (Specify only highest grad Elementary/Secondary (0-12) 3 R D		(0		,			g			MPLOY		
by the be der	BE COMPL	17. FATHER'S NAME (First, Middle, Last) WILLIE MACK						E	RAN	E (First, Middl	e, Melden Sc DUBOS	omeme) SE		
E, MAH by be retained page 5 should be notified	2	190. INFORMANT'S NAME (Type/Print) Karen Dubose 200. METHOD OF DISPOSITION	-Mc Coy		619	FUR	LEY	AVE		ALTO	MD.	2120	6	
ALIIMOKE, death. Page 6 may by tuneral director, page I. examiner must be		X Burlel 2 Cremation 3 Re-	- 0	BALT	IMO	RE C	EM.	DEC D ADDRES IN E	S OF FACE	CRUGO	95 S FU	JNERA	O,M	MD. HOME
bod within 24 hours after descending, or removal. event, the medical exa		23. PART I. Enter the diseases, or shock, or heart failure IMMEDIATE CAUSE (Final disease or condition resulting in death)	a. Prosto	cause the dese on each line	Pan	not enter	tha mod	C .	PRE,	as cardiac	Dr respira	BAL'I	·O , M	Approximats Interval Between Onset and Death 3 years.
ath certificate be executed intending physician and contail Hygiene prior to burial, or other traumatic en	CERTIFICATION	Sequentially list conditions, If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): d												
law requires that the death law requires that the death so been signed by the attect. of Health and Mental 23 shows any Injury, or	MEDICAL	PART II. Other eignificent condition								_ 10	PERFORM	ED?	C	VERE AUTOPSY FINDINGS MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? YES 2 NO
N: The taw ficate has be State Dept.	PHYSICIAN:	DID TOBACCO USE CON 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO	HOSPITAL:	26. PLA	E OF DEA	TH (Check of	only one)	UNC	ERTAIN					
PHYSICIA this certification with the riced, or	BY PHYS	27. MANNER OF DEATH 1 Netural 5 Pending 2 Accident Investigation	1 Inpatient 2 I	INJURY	28b. TIM		28c. INJU WO	JRY AT RK?	:	Other (Sp 28d. DESCRIE		OSPIC URY OCCUR		
OR ATTENDING FOR DIRECTOR: After I hours after death	8	3 Suicide 6 Could not be determined	28e. PLACE OF building, e	INJURY — At ho atc. (Specify)	rme, farm,	street, facto	ory, office		-	City or To	N (Street end wn, Stete)	f Number or I	Rural Rou	ite Number,
TAL	COMPLET	29a. CERTIFIER 1 CERTIFYING PHYS	ER: On the best of exa										Ruse(s) c	and manner es stated.
TO THE HOSP TO THE FUNEI be filed within	TO BE	296. SIGNATURE AND TITLE OF CERTIFIE CONCERN CONTROL OF PERSON W	aulki	LUNS E OF DEATH (ITE	M 27) /Time	Print)		29c. LICE	NSE NUMB	73	2			Month, Day, Year)
		DR. KENDALL FAUL 31. DATE FILED (Month, Dey, Year)		O DULAN			RD	, TO	OWSON	, MD	2120	4		
		DEC 2 0 1995	hi Mudia	Radall										DHMH-16 Bev 1//



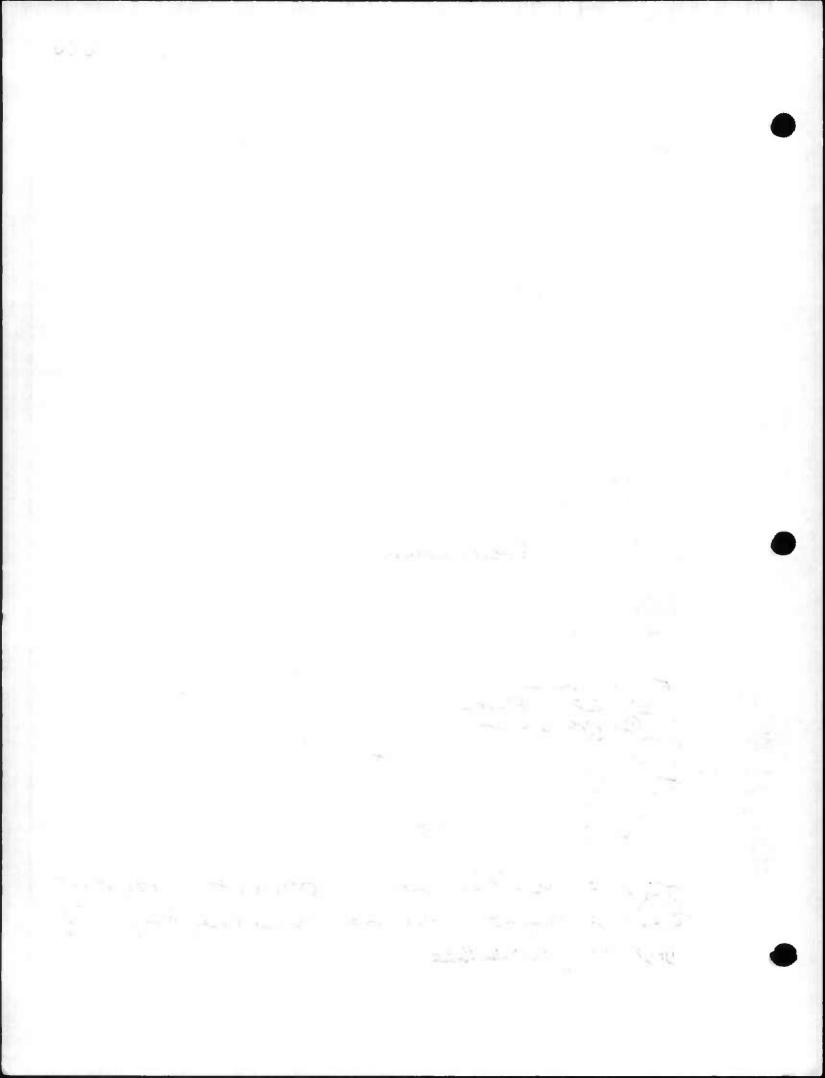
DHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

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1	1. DECEDENT'S NAME (FI	rst, Middle, Last)						2. DATE	OF DEATH	DAY	PASY	TIME OF DEATH
				Harp					Dec. 16, 1995			1.4	:40p
	110000		1 M 2 D F		yrs. last birthday) YRS.	MONTHS	DAYS	HOURS MIN.	(Month	n, Day, Year)		Country)	ACE (State or Foreign
	141-03-1907	44	82	Tho.	0.000			Sept. 7, 1913			New Jersey		
5	9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH Annapolis Convalescant Center Annapolis Anna Arundel												
DIRECTOR	10a. STATE 10b. COUNTY MD Anne Arundel				10c. CITY, TOWN OR LOCATION Crownsville								od. INSIDE CITY LIMITS? P YES 2 NO
- 1	10s. STREET AND NUMBI	101. ZIP CODE				10g. CITIZEN O							
	1308 Tall TimbersDrive					21032				Anne A			del
BY FUNERAL	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced 12. WAS DECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR DAY				2 NO It yes, specify Cuban, Mexi				PANIC ORIGIN? (Specify Yes or No- 14. Rican, Puerto Rican, etc.)			4. RACE -	American Indian, White, etc.
EIED	15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)				18a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)				166. KIND OF BUSINESS/INDUSTRY			STRY	
M	9				Manage	r			1	A & P	Store	s	
g	17. FATHER'S NAME (First)							16. MOTHER'S N	AME (First, I	Middle, Malde	n Surname)		
ш	William Har	per						Sus	san Sa	aunder	rs		
10 B	19a, INFORMANT'S NAME	(Type/Print)			19b. MAILIN	O ADDRES	S (Street	and Number or Rura	/ Route Numi	ber, City or To	wn, State, Zip C	lode)	
-	Lois M. Cre	monni			1308	Tal:	L Ti	mbers Dr	c. Cro	ownsv:	ille.	MD 2	21032
	20a. METHOD OF DISPOS		moval from Stata		PLACE AND DAT			(Name	DAT	E 20c. L	OCATION — CI	ty or Town	, State
	4 ☐ Donation 5 ☐ Oti	her (Specify)		— Но	llywood	Memo	oria	1 Park	112	/2h UI	nion,	W	
	21. SIGNATURE OF TUNE	MAL SERVICE I	JOENSEE /	111				NO ADDRESS OF F		Llomo	77 7		
	Hardesty Funeral Home, P.A. 12 Ridgely Ave. Appapolis MD 2											1401	
CERTIFICATION	Sequentielly list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):												
PHYSICIAN: MEDICAL CE	PART II. Other algnificant conditions contributing to death but response to the part of th									PERFORMED? 1 YES 2 KNO		C	FERE AUTOPSY FINDING MAILABLE PRIOR TO OMPLETION OF CAUSE F DEATH? YES 2 NO
KSI	1 VES 2 NO 1 Inpatient 2 ER/Outpetient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify)												
	27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year)				28b. Ti	28b. TIME OF INJURY AT WORK? M 1 YES 2 NO				28d. DESCRIBE HOW INJURY OCCURED			
LED BY	2 Accident Investigation 3 Suicide 8 Could not be determined 28- PLACE OF INJURY — At building, etc. (Specify)					At home, term, street, factory, office				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
COMPLET	29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the basis of axamination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(a) and manner as state.												
BE	29b. SIGNATURE AND TITLE OF CERTIFIER CONTROL OF CERTIFIER				- 6-3	29c. LICENSE NUM			コフォートは			211	Month, Day, Year)
2	30. NAME AND ADDRESS	OF PERSON Y	MHO COMPLETED CA	ER	ATH (ITEM 27) (Tyr	oe, Print)	زدد	3 Medi	call (Pku	An.	ונסגר	21401
	DEC2	1995	32. REGISTI	RAR'S SIGN	ATURE							0	

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.



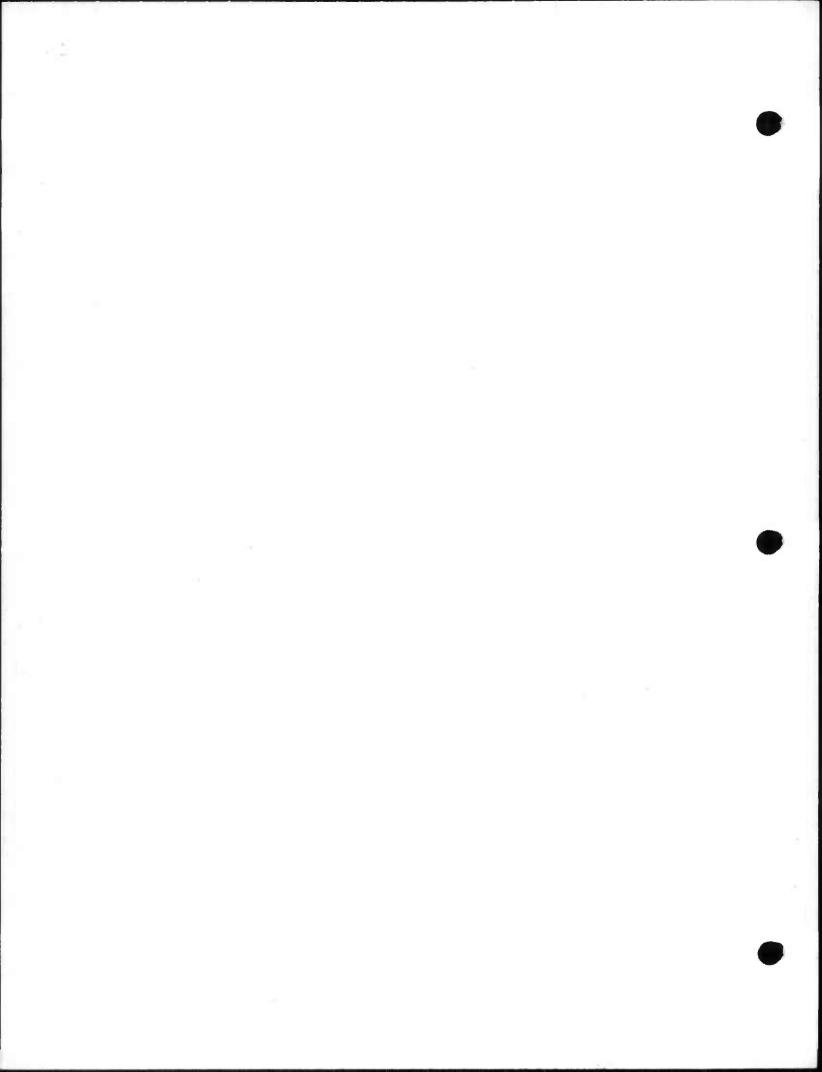
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

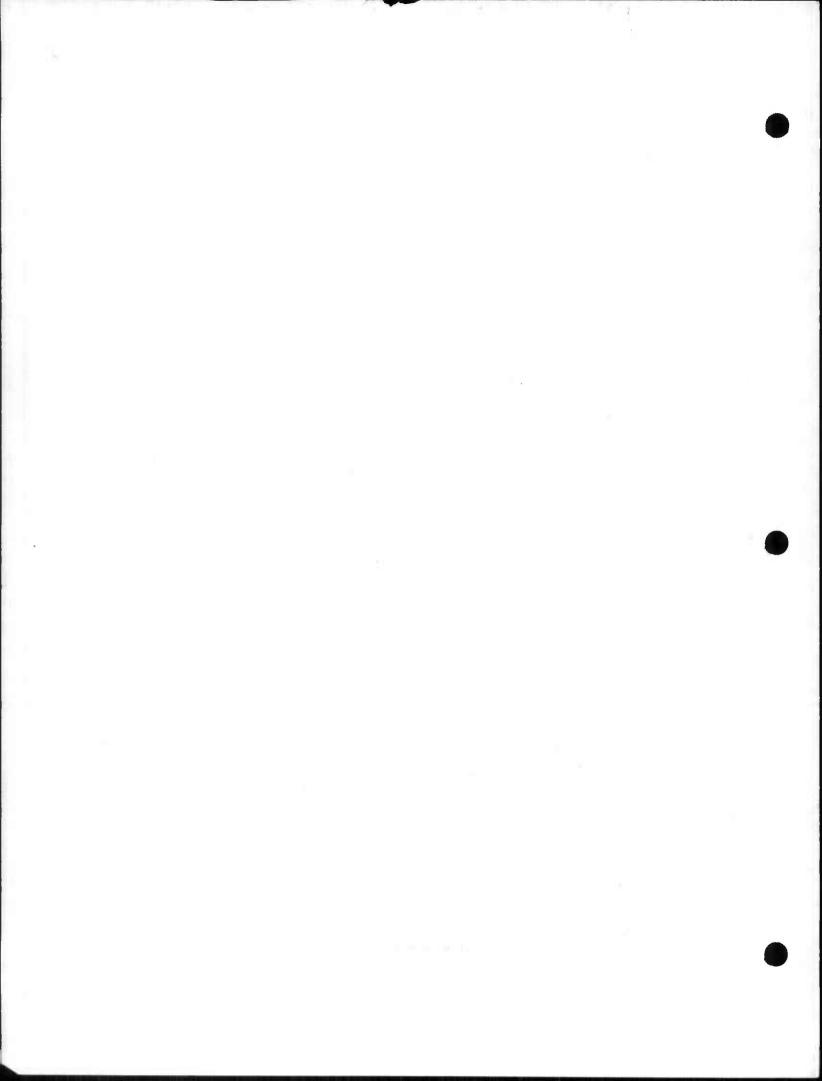
IMPORTANT: If Nem 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Iteml, Film730, 12/19/95, 1t
FOR
STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAR		OLITI	IFICALE	OF DEATH		REG. NO.				
	1. DECEDENT'S NAME (First, Middle, Last)		KANE			2. 0	ATE OF DEATH		3. T	TIME OF DEATH	
1	CLAUDIA		KAIN			MONTH DAY YEAR			1 1 1 M		
		SEX 6	. AGE (In yrs. last birth	day) IF UNDER	YEAR IF UNDER 24 H		DECEMBER 15.199			95 11:11 p M	
	216-30-1503	□ M 2 反 F		NONTHS		M. (A	Aonth, Day, Year)		Country)		
	9s. FACILITY NAME (If not institution, give street	**	02 "	-		_	PT.17,			INIA	
æ	The second of th										
2	THE JOHNS HOPKINS HOSPITAL BALTIMORE CITY N/A										
<u>မှု</u>	10a, STATE 10b, COUNTY										
DIRECTOR	MARYLAND	N/A	1	CITY, TOWN O		TMS			1	INSIDE CITY LIMITS?	
	10e. STREET AND NUMBER	N/ A		DAL.	CIMORE C	T.T.Y				YES 2 NO	
FUNERAL	2733 E. MONUMENT	CMD D D	magra e	ET OOD	101. ZIP CODE	_		10g. CITIZEN	OF WHAT	COUNTRY?	
Ä					2120			U.S.	.A.		
5	11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 1 Never Married 13. WAS OECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— Black, White, stc.) 14. RACE — American In Black, White, stc.								merican Indian,		
BY	IF YES, GIVE WAR OR DATES TO SOCIAL									BLACK	
	15. DECEDENT'S EDUCATI	ON .								DETICK	
COMPLETED	(Specify only highest grade com	pleted)	(Give kin	NT'S USUAL OC d of work done d OT use retired.)	CUPATION uring most of working		16b. KIND OF BUS	BINESS/INDUST	RY		
٦		ollege (1-4 or 5+)		SEKEEL	PER			MOTI	CT T		
3	17. FATHER'S NAME (First, Middle, Lest)	,							بان		
	RUBEN H. BOYD				18. MOTHER!	S NAME (FI	E HENDI	Sumame)			
H			· · ·								
2	19s. INFORMANT'S NAME (Type/Print)				(Street and Number or F		Number, City or Town	n, State, Zip God	(e)		
	JOYCE WILLIAMS		52	8 N. F	LLWOOD	bal	to. Md.	2120)5		
	20s. METHOD OF DISPOSITION 1 ↑ Burisl 2 □ Cremation 3 □ Removal	from State	20b. PLACE AND D	ATE OF DISPOSIT	TION (Name of		DATE 20c. LO	CATION - City	or Town, S	tate	
	4 Donation 5 D Other (Specify)		MT. ZI	ON CEM	ETERY 1	2/21	/95 BA	ALTO, M	1D.		
	21. SKRATURE OF FUNERAL SERVICE LICENS	ME	0	22. N	LVIN B.	F FACILITY	IICCC DI	INIDDAT		-	
	(Murnit) A	-1110	D. S.		412 E. P						
	23. PART I. Enter the diseases, or com	plicatione that c	sysed the death. I	Do not enter t	he mode of dving.	such as o	errilec Dr reani	DALI V	O, MD	Approximate	
	anock, or neert failure. List	Dnly Dne cause	ón each line.				or reap.	atory arrest,		Interval Between	
l li	IMMEDIATE CAUSE (Fins)				a.					Onset and Death	
		11	- 10-11	1 . 1 6	2.00				i	5.	
ļ	resulting in deeth)	ACUT	E ASTH	MA 2	YACER B	10101	J			5yrs	
	resulting in deeth) a	HULT DUE TO (O	E ASTH	MA ?	PRACENB	47101	J			5yrs	
ION	Sequentially list conditions, b	DUE TO (O	R AS A CONSEQUENCE	Œ OF):	EXACERB	Anoi	J			5yrs	
ATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING	DUE TO (O	AS A CONSEQUENC	Œ OF):	EXACENB	101	V			5yrs	
IFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury	DUE TO (OI	AS A CONSEQUENC	CE OF):	PACERB	ATION)			5yrs	
RTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING	DUE TO (OI	R AS A CONSEQUENC	CE OF):	PACERB	100	J			5yrs	
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST	DUE TO (OI	R AS A CONSEQUENC	CE OF):						5yrs	
AL CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events	DUE TO (OI	R AS A CONSEQUENC	CE OF):			. 24a. WAS AN			E AUTOPSY FINDINGS	
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COMPLETED BY PHYSICIAN: MEDICAL	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST DID TOBACCO USE CONTRIB 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending Investigation 2 Accident Investigation 3 Suicide a Could not be determined 29e. CERTIFIER (Check only One) 29b. SIGNATURE AND TITLE OF CERTIFIER	DUE TO (OI DUE TO	R AS A CONSEQUENCE R AS A CONSEQUENCE R AS A CONSEQUENCE R AS A CONSEQUENCE RAS A CON	YES N DEATH (Check or OTHER, A 4 Nursi TIME OF INJURY M TIME OF INJURY M TIME OF INJURY M TOTAL CONTROL OF INJURY M TOTAL	Ing Home 5 Resident WORK? 1 YES 2 NO. To, office No. office Resident Resid	n in Part I	24a. WAS AN PERFORI 1 YES 2 Wher (Specify) DESCRIBE HOW the state of	MED? AG NO JURY OCCURE and Number or Re are as stated. d dus to the cau 29d. DATE SIG	AMAL COM OF D 1 D D D D D D D D D D D D D	E AUTOPSY FINDINGS ABLE PRIOR TO PLETION OF CAUSE EATH? YES 2 \(\sum \) NO Number. manner as stated. h, Day, Year)	
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BE COMPLETED BY PHYSICIAN: MEDICAL	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST DID TOBACCO USE CONTRIB 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Naturat 5 Pending Investigation 3 Suicide a Could not be determined 29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: O	DUE TO (OI DUE TO	R AS A CONSEQUENCE R AS A	YES NDEATH (Check or INJURY M	Ieriying cause givet O UNCERT Thy one) The second of th	TAIN 2 10 January 1 Janua	. 24e. WAS AN. PERFORI 1 TYES 2 Wher (Specify) DESCRIBE HOW the Control (Street is 27) or Rown, State) Cause(iii) and manufacts and place, and	MED? SE NO JURY OCCURE and Number or Ri ner as stated. d due to the cau 29d. DATE SIG	AMAIL COMM OF D 1 D D D Unal Route A NED (Month Llubly)	E AUTOPSY FINDINGS ABLE PRIOR TO PLETION OF CAUSE EATH? YES 2 \(\sum \) NO Number. manner as stated. h, Day, Year)	
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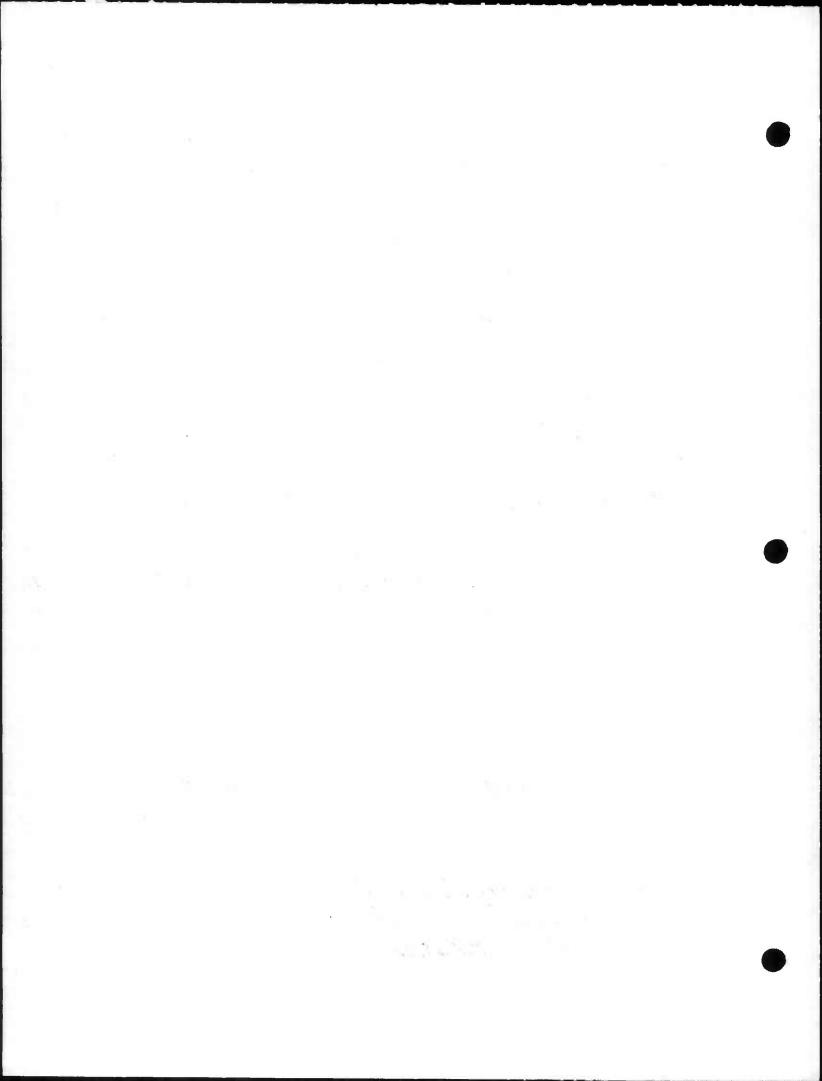
	1 - STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT (CERTIFICATE	OF DEATH	MENTAL HYGIENE REG. NO.								
	1. DECEDENT'S NAME (First, Middle, Last)	0. 02/1111	2. DATE OF DEATH		3. TIME OF DEATH						
	MIRIAM LURIE		DEC. 5,199	5 YEAR	6:15 A						
	4. SOCIAL SECURITY NUMBER 5. SEX 8. AGE (In yrs. last birthday) F UNDER 1	YEAR IF UNDER 24 HRS.	7. DATE OF BIFTN (Month, Day, Year)	Count	HPLACE (State or Foreign try)						
	215-32-9568 B 1 M 2 X F 87 YRS.		JAN. 10,19		RYLAND						
DIRECTOR		OWN OR LOCATION OF D	EATN	9c. COUNTY OF I	DEATH						
3EC	10e. STATE 10b. COUNTY 10c. CITY, TOWN OR	LOCATION			10d. INSIDE CITY LIMITS?						
	MARYLAND BALTIMORE BALTIMO 100. STREET AND NUMBER BALTIMORE	RE 101. ZIP CODE		10g. CITIZEN OF	1 TYES 2 NO						
ER/	725 MT. WILSON LANE, APT. #733	21208		U.S.A	Α.						
BY FUNERAL	1 Never Married 2 Married FORCES? 1 YES 2 NO It	S DECENDENT OF HISPA res, specify Cuben, Mexic YES 2 NO Speci		or No— 14. RAC Blac Spec	E — American Indian, ck, White, etc. city: WHITE						
COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 16a. DECEDENT'S USUAL OCC (Give kind of work done during high Do NOT use retired.)	UPATION ring most of working	16b. KIND OF BUS	INESS/INDUSTRY							
MP	12 HOMEMAKER		AT H								
BE CO	17. FATNER'S NAME (First, Middle, Last) MEYER SUMERS	LI	AME (First, Middle, Meiden S LLIAN	V	VAGMAN						
TO			TO., MD. 212								
	20a. METHOD OF DISPOSITION tX Burlal 2 Cremetton 3 Removal from State 4 Donation 5 Vother (Specify) 20b. PLACE AND DATE OF DISPOSIT cemetery, crematory or other place) BETH TFILOH	ION (Name of	12/07/95	CATION — City of T BALTIMOS							
	Now By S		N & BROS.,I	NC.							
-	23. FART I. Enter the diseases, or complications that caused the death. Do not enter ti		STOWN RD., B		J. ZIZIS Approximata						
	ehock, or heert feliure. List only one course on each line. IMMEDIATE CAUSE (Final	9		atory arroat,	Interval Between Onset and Death						
	disease or condition at the second se										
ATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING										
CERTIFICATION	CAUSE (Disease or Injury that Initiated evente resulting in death) LAST										
	0.										
MEDICAL	PART II. Other eignificent conditions contributing to death but not resulting in the und	erlying couse given in	1 Part I. 24s. WAS AN PERFOR	MED?	b. WERE AUTOPSY FINDINGS AMILABLE PRIDR TO COMPLETION OF CAUSE OF DEATH?						
	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES N	O N UNCERTA			1 YES 2 NO						
AN	25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check or										
SIC	EXAMINER? 1 YES 2 NO HOSPITAL: 1 Inputient 2 ER/Outpatient 3 DOA 4 Nursi	ng Home 5 🗆 Residence	5 Nother (Specify)	MiciL	HARY GUIECH						
Y PHYSICIAN:	27. MANNER OF DEATN 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 2 INJURY M	Sc. INJURY AT WORK?	28d, DESCRIBE NOW IN		, w , wone						
TED BY	2 Accident investigation 3 Suicide 8 Could not be determined determined 26s. PLACE OF INJURY — At home, tarm, street, tactor building, stc. (Specify)	y, office	281. LOCATION (Street s City or Town, State)	and Number or Rural	Route Number,						
COMPLET	29e. CERTIFIER (Check only one) CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time one) Description on the basis of examination and/or investigation, in my open				(a) and manner as stated						
	29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NU									
TO BE	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)	D 16		DEC	. 5, 1995						
	C. VERGARA - SOARES 100 N. BRE	ADWAY S	ST. BALT	MD.	2/23/						
	31. DATE FILED (HOME PRICE 18 1995) 32. REGISTRAR'S SIGNATURE										
	. 0				DNA						



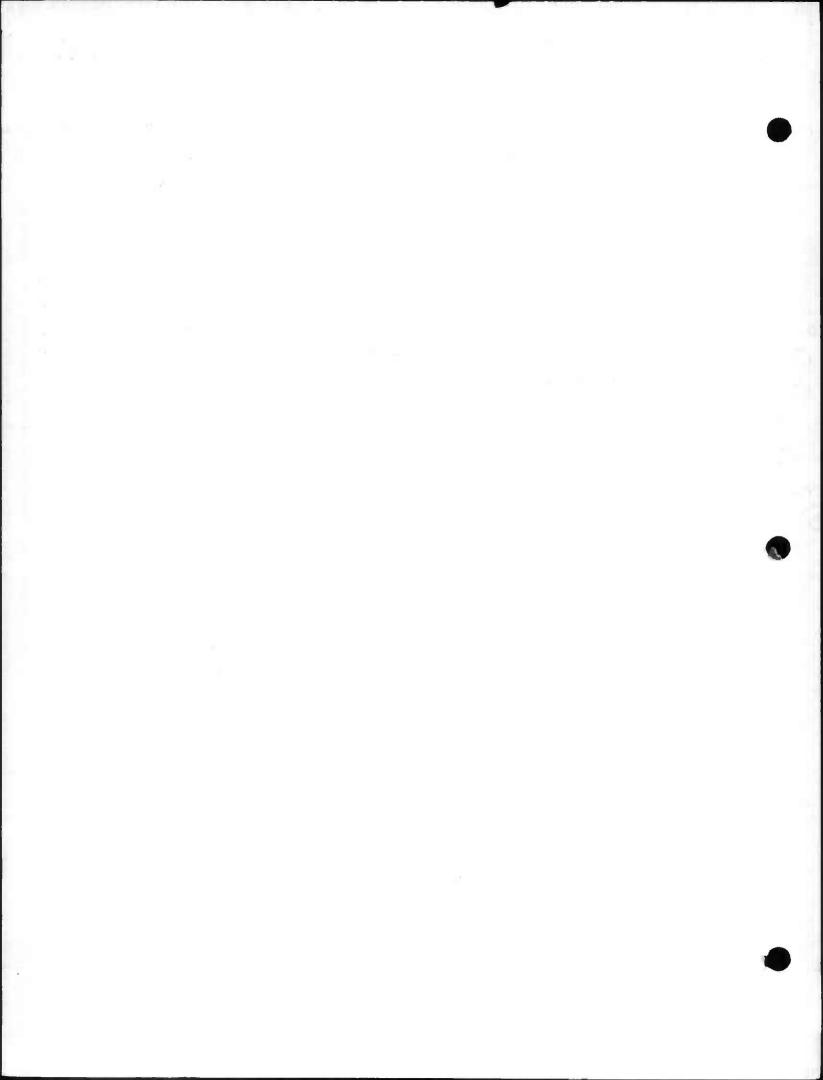
FOR STATE REGISTRAR 1 -

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

	1. DECEDENT'S NAME (First, Middle, Last)	>	2. DATE OF DEATH	3. TIME OF DEATH
	WILLIAM MICL	OY	DEC 18	95 2056 Pm
		DER 1 /EAR IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)	8. BIRTHPLACE (State or Foreign Country)
	253-28-2476 1042 = 70 YRS. MONTH	S DAYS HOURS MIN.	April 28,19=	5 Alabama
	9e. FACILITY NAME (If not institution, give street end number) 9b. 0	TY, TOWN OR LOCATION OF D	EATH 90	COUNTY OF DEATH
DIRECTOR	Suburban Hospital 1	sethesaq	. /	uont go Mery
딦	RESIDENCE OF DECEDENT 10s. STATE 10s. COUNTY 10c. CITY. TOW	N OR LOCATION		10d. INSIDE CITY
<u> </u>	WASH, D.C. NONE WAS	hington ?	0.0	1 YES 2 NO
	40. OTDEET AND AUGUSED	101. ZIP CODE	110	g. CITIZEN OF WHAT COUNTRY?
R.	7703 12th Street N.W.	2001	2	U.SA
FUNERAL	11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED	13. WAS DECENDENT OF HISPA	NIC ORIGIN? (Specify Yee or I	No - 14. RACE - American Indian,
L	1 Never Merried 2 Merried FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES	if yes, specify Cuben, Mexicon 1 ☐ YES 2 ☐ NO Specific		Black, White, etc.
B \	3 Widowed 4 Divorced			BIGER
COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed) 16e. DECEDENT'S USUAI (Give kind of work of the both of the completed) 17. Decement of the complete of the c	ne during most of working	Maye	
ا لِـّ	Elementary/Secondary (0-12) College (1-4 or 5 +) Manage	·.,		DIVISION
M	17. FATHER'S NAME (First, Middle, Last)	18. MOTHER'S NA	AME (First, Middle, Meiden Surr	
	William Mc Coy SR	Wil	lie Lee	Thomas
8		ESS (Street and Number or Rural	Route Number, City or Town, S	
٩	Savannah v. McCoy 7703 1	2th ST. N.W	. WAShingto	m. S.C. 20012
	20a. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISI	POSITION (Name of		ION - City or Town, State
	1 Burtel 2 Cremation 3 Removal from State Commettery, cremetery, cremetery or other ple 4 Donation 5 Other (Specify) CO N	ational cem.	12/2/2- Tria	ingle V9.
		AND MARKE AND ADDRESS OF CO	COLUTY COLUMN	
	Kolreit B. Balandy.	Chinn Fune	MIL SCHOOL RO	larlya,
	23. PART I. Enter the disesses, or complications that counsel the deeth. Do not en	ter the mode of dying, suc		ory srrest, Approximate
	ahock, or heart fallure. List only one cause on sech line. IMMEDIATE CAUSE (Fine)			Interval Between Onset and Death
	disease or condition PN/F1/MAAA/	A		4 DAYC
	DUE TO (OR AS A CONSEQUENCE OF)	*		
z	Sequentially list conditions, If any leading to immediate b. CORD CONT DUE TO (OR AS A CONSEQUÊNCE OF):	USION (CERVICAL	11 DA YS
잂	Sequentially list conditions, If any, leading to immediate	4-	,	
2	DUE TO GOD AS A CONDECUTENCE OF	ONTUSION		11 DMS
E	that initiated events resulting in death) LAST			II DAY
CERTIFICATION	d//F LL			11 0073
	PART II. Other algnificant conditions contributing to death but not resulting in the	underlying cause given in	Part I. 24a, WAS AN AUT PERFORME	
EDICAL			1 - YES 2	COMPLETION OF CAUSE
ME			``	1 TES 2 NO
	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES	NO UNCERTAL	NE	
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINED?' AND DESCRIPTION OF DEATH (Ch. 1971) BY AND THE STREET OF DEATH (Ch. 1971) BY AND THE STR	ter:		
YSI	1 TES 2 NO 11 Inpatient 2 ER/Outpatient 3 DOA 4	Nursing Home 5 - Residence		
F	27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 1 Netural 5 Pending 28e. DATE OF INJURY (Month, Day, Year)	28c. INJURY AT WORK?	28d. DESCRIBE HOW INJU	RY OCCURED
ВУ	2 Decident Investigation 1 E 7 7	1 1 123 2 2 100	PELL VOS	Number or Rural Route Number,
ED	6 Could not be building, etc. (Specify)	- Conce	City or Town, State)	#10
LET	29e. CERTIFIER			
MP	(Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at to the best of my knowledge, death occurred at to the best of my knowledge, death occurred at to the best of my knowledge, death occurred at to the best of my knowledge, death occurred at to the best of my knowledge, death occurred at to the best of my knowledge, death occurred at to the best of my knowledge, death occurred at to the best of my knowledge, death occurred at to the best of my knowledge, death occurred at the contract of the best of my knowledge, death occurred at the contract of the best of my knowledge, death occurred at the contract of the best of my knowledge, death occurred at the contract of the best of my knowledge, death occurred at the contract of the best of my knowledge, death occurred at the contract of the best of my knowledge, death occurred at the contract of the best of the be			
COMPLETED			TO I SEE THE SEE THE SEE	
BE	296. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NU	. 0. 6	Pd. DATE SIGNED (Month, Day, Year)
2	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)	0 10070	74	VEC 2013
		ENWOOD R	A ROTA	ESDO MB 20812
	31. DATE FILED (Month Day Year) 32. REGISTRAR'S SIGNATURE	COUNTRY	D DBIN	7/10-011/100
	DEC 2 0 1995 Juli Drucker harlet			

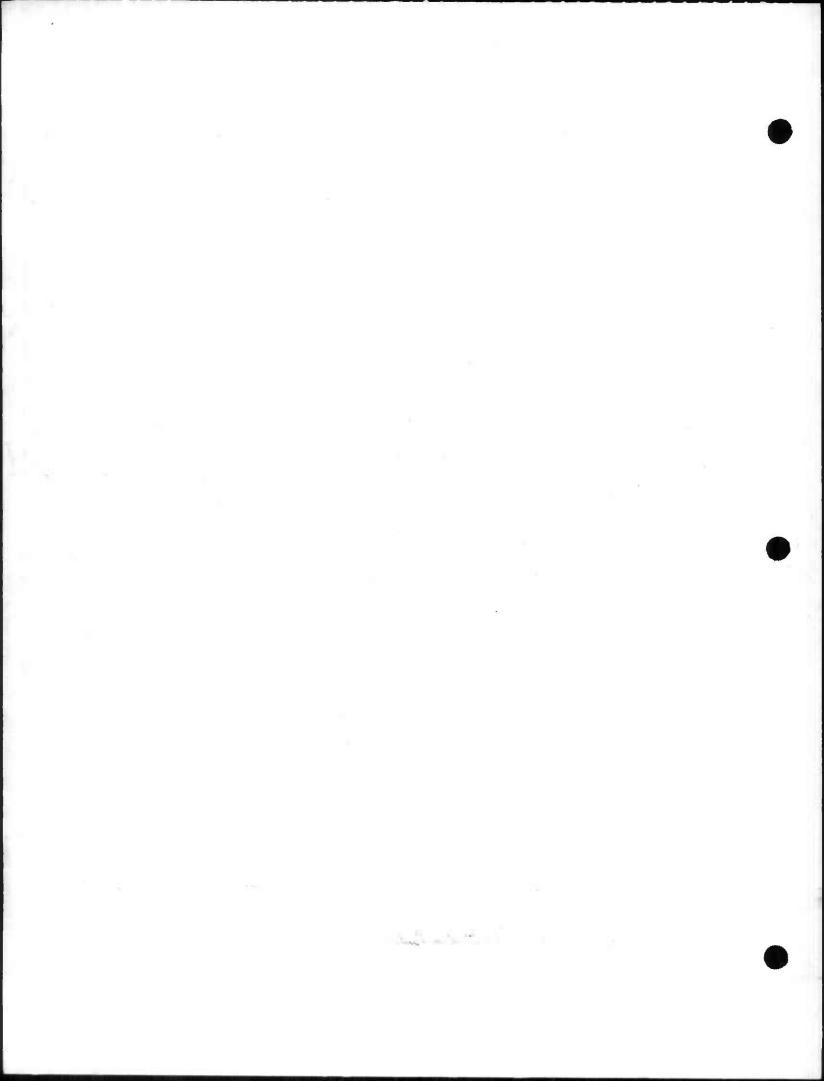


1. DECEDENT'S NAME (First, Middle, Last) AY ON A 4. SOCIAL SECURITY NUMBER	WA					DEAT).			
	141	ILLIN	145	,				DE S	- 16		YEAR 195	10	OF DEATH
220366186	5. SEX 1 M 2 X F	6. AGE (In yrs. I	lest birthday) YRS.	IF UNDER	DAYS	IF UNDER	MIN.	7. DATE (Month	OF BIRTH 9	11/32	8. BIRTH Countr	v)	CAROLI
9e. FACILITY NAME (If not institution, give s LIBSTY ME) RESIDENCE OF DECEDENT		MER				TIV		EATH		9c. COU	Ti M	EATH	C17Y.
MARYLAND BALT		CITY		Y, TOWN			CIT	TY.				LIN	SIDE CITY HTS? ES 2 NO
3700 GLEEN SPRI	NG APT	211 BALTIM	tore, m	52121	101	. ZIP COD		211		-	S.A		JNTRY?
11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDEN FORCES? 1 IF YES, GIVE V	T EVER IN U.S. / YES 2 VIAR OR DATES	NO		If yea, ap-		n, Mexico	en, Puerto	17 (Specify Ye Rican, atc.)	a or No—	14. RACE Black Speci	, White,	icen Indien, etc.
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8TH 15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) COOK/HOME CARE PROVIDER 16b. KIND OF BUSINESS/INDUSTRY RESTAURANT/PRIVATE RESTAURANT/PRIVATE HOMES 17. FATHER'S NAME (First, Middle, Lest)													
17. FATHER'S NAME (First, Middle, Last) ISAIAH M	ILLINGS					18. MOT	NER'S NA	ME (First, I	MARY	n Surname)			
DOROTHY LEWIS									SE, M			0	
Burial 2 Cremation 3 Ram	oval from Stata		EANDDATE GMMEN				D	EC.	20c. LG	95BA			
24. SOMATURE OF PUNERAL SERVICE LA	CALLOVA	o D	1.	C	ALV:		ss of FA	CRUC	GS F	UNER	AL H	IOMI	E
shock, or heart failure. List only one dause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Olsesse or Injury) DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):													
CAUSE (Disease of Injury that Initiated eventa resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): C & IL & B LTL d. C & IL & B LTL													
PART II. Other algorificant condition							given in		24a. WAS AI PERFO 1 YES	PMED?	24b.	COMPLE OF DEA	UTOPSY FINDINGS LE PRIOR TO TION OF CAUSE TH?
25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:		ACE OF DEA	TH (Check	only one)] 0140	EKIAI	IN L					
1 YES 2 NO 27. MANNER OF DEATH	HOSPITAL: 1)X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 26e. DATE OF INJURY 28b. TIME OF 26c. INJURY AT 28d. DESCRIBE NOW INJURY OCCURED									_			
1 Natural 5 Pending investigation	(Month, E	Pay, Year)	IN	JURY M	1 🗆	YES 2	NO						
3 Suicide 6 Could not be 4 Nomicide datarmined	building,	OF INJURY — At etc. (Specify)	nome, rarm,	street, rec	nory, ome				ATION (Street or Town, State		or Hurai F	Nure Nur	7Der,
29e. CERTIFIER (Check only one) 2 MEDICAL EXAMIN	The second second second) end ma	nner sa stated.
296. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month) 47607 DEC 167											(Month,	Day, Year)	
		ms	•			104	76	07		D 0	56	16"	1995



BALTIMORE, MARYLAND 21215-0020

		3, /3(J, Item				_	_		I.I	1.				
	FOR STATE REGISTRAR		STATE OF N	MARYLAND C	/ DEPAR	ICATE	OF H	EALTH DEA	AND I	MEN.	TAL HYGI REG.				
	1. DECEDENT'S NAME (First,	Middle, Lest)	on PEG	GY CAM	1PBEL	L MA	ADIS	ON		N MC	ATE OF DEAT	DAY	199	YEAR	3. TIME OF DEATH 2:35 Q M
- 8	4. SOCIAL SECURITY NUMBER	ER	5. SEX	6. AGE (In yrs.	last birthday)	IF UNDER	1 YEAR	IF UNDER		7. D/	ATE OF BIRTH				PLACE (State or Foreign
	220-20-3809)	1 🗆 M 2 💢 F		66 YRS.	MONTHS	DAYS	HOURS	MIN.	pct		192	29		aryland
	9a. FACILITY NAME (If not in	stitution, give st	treet and number)			9b. CITY	, TOWN C	R LOCATI	ON OF DE	EATH		90	c. COUP	ITY OF DE	EATH
DIRECTOR	Sinai Hospi					Ba	alti	more						n/a	
E I	10a. STATE	10b. COUNTY	1		10c. CIT	Y, TOWN (OR LOCAT	ION				-			10d, INSIDE CITY LIMITS?
	Maryland	r	ı/a		В	altir	nore								1 XYES 2 NO
FUNERAL	10e. STREET AND NUMBER						101	. ZIP COD	E			10	g. CITI	ZEN OF W	THAT COUNTRY?
E	8119 Arrowh	nead Ro	oad					2	1208					US	SA
S	11. MARITAL STATUS		12. WAS DECEDEN	TEVER IN U.S.							IIGIN? (Specif erto Rican, etc		No-	14. RACE Black	— American Indian, White, stc.
ВУГ	1 Never Married 2 3 X Widowed 4 Divo			MAR OR DATES				2 NO			rio riioari, eio	~7		Specif	ly:
				T.,											Black
		EDENT'S EDUC y highest grade			(Give kind of life. Do NOT u	work done	during mo	on st of worki	ing		16b. KIND OF	BUSINE	SS/IND	USTRY	
COMPLETED	Elementary/Secondary (0	0-12)	College (1-4 or 5 5+	+)		ncipa				,	D-1+in		0:	L. D	ublic Schoo
M	17. FATHER'S NAME (Flist, M	licidio (not)	JT.		PII	ICTP	11	10 MOT	HED'S NA		rst, Middle, Me			Ly P	ubite Selloo
	William Cam								va B			noen our	101110)		
BE	19a, INFORMANT'S NAME (1	19b. MAILING	ADDRES	S (Street a			_	Number, City o	Town St	tete. Zio	Code)	-
5	Joy Marshal				6645						olumbi				1 21044
	20a, METHOD OF DISPOSIT 1 X Burlai 2 Crematic	TON	oval from State		CE AND DATE			me of		1	DATE 20	LOCATI	ION —	City or To	wn, Stata
	4 Donaflon 5 Other				tus M	emor:	ial :			De	c 15	Balt	imo	ore (County, MD
	21. SIGNATURE OF FUNERA	L SERVICE LIC				22.	NAME A	ND ADDRE	SS OF FA	CILITY	Nutte	r Fu	ıneı	cal E	Homes, Inc.
	Steve	N	tasker				250 Ba1	l Gw timo	ynns re.	Fa	alls P yland	arkw 21	vay	5	
	23. PART i. Enter the d					not enter									Approximata
	IMMEDIATE CAUSE (Fil		List only one ce	use on eech ii	ine.										Onset and Daath
	disease or condition	→	a. Overwi	helmin	g I	rec	Hist	7							days
	resulting in Guetin)							-							
z	L		Intrac	table	Asol	Hes									marths
5	Sequentially list condit if any, leading to imme		DUE TO	OR AS A CON	SEOUENCE C	OF):									
CA	cause. Enter UNDERLY CAUSE (Disease or inju		cirrhe												years
분	that initiated events resulting in death) LAS	T.	Hepat	O (OR AS A CON	SEQUENCE (OF):									years
CERTIFICATION	resolding in duality and		d. 11930G	1115											years
_	PART II. Other aignifica	ent condition	na contributing to	death but no	t resulting	In the u	nderlyln	g cause	given in	Part		S AN AUT		24b.	WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
MEDICA	Dabets 1	Vellita	s Cerebi	ovascul	ar Ac	ciden	+					ES 2	1		COMPLETION OF CAUSE OF DEATH?
	Stage II	Sacra	el Decu	bitus	VIce	~						1			1 TYES 2 NO
	DID TOBACCO L				EATH Y	ES 🗌	NO E	UN	CERTAI	NE]				1
IA	25. WAS CASE REFERRED 1	TO MEDICAL		26. PI	LACE OF DEA										
PHYSICIAN:	EXAMINER?		HOSPITAL:	☐ ER/Outputlent	3 🗆 DOA	OTHE 4 Nu		10 5 🗆 F	Realdence	6 🗆	Other (Specify)			
ΉÝ	27. MANNER OF DEATH		28a. DATE O	F INJURY Day, Year)	28b. TII	ME OF		JURY AT		28d.	DESCRIBE H	DUN INJU	JRY OC	CURED	
BY F	1 Netural 5 2 Accident	Pending Investigation	(IMOTALL)	Day, roor,		М	1 🗆		□ NO						
	0 0 0 0 1 1 1 1 1 1	Could not be	28e. PLACE	OF INJURY At	home, ferm,	street, fed	tory, offic	in .			LOCATION (S City or Town,		Number	or Rural F	Route Number,
TED	4 Homicide	datarmined										,			
7	29a. CERTIFIER (Check only	TIFYING PHYS	ICIAN: To the beat of	of my knowledge,	, death occur	red at the	time, data	and plac	a, and du	e to the	e cause(a) an	d manner	r aa stel	led.	
COMPLET	0001	DICAL EXAMINE	ER: On the beals of	examination and	or investigat	lon, In my	opinion, o	death occi	ured at the	e time,	data end plac	ce, end d	ue to th	ne cause(s	a) and menner as stated.
ECC	29H SWINATURE AND TITLE	E OF CERTIFIE	R					29c. LIC	CENSE NU	IMBER		21	9d. DAT	E SIGNED	(Month, Day, Year)
Ø	1112-	7						ASS	1401	32	1 HP 94	40 1	1)0	cem	her 10, 1995
5	30. NAME AND ADDRESS	F PERSON WI	O COMPLETED CAL	USE OF DEATH (ITEM 27) (Typ	e, Print)									
	HELEN	TOYCE	Powell	52	NAI	AUS	DITH	2	BA	LTI	MORE	ME)		
			0.0	A STATE OF THE REAL PROPERTY.										-	



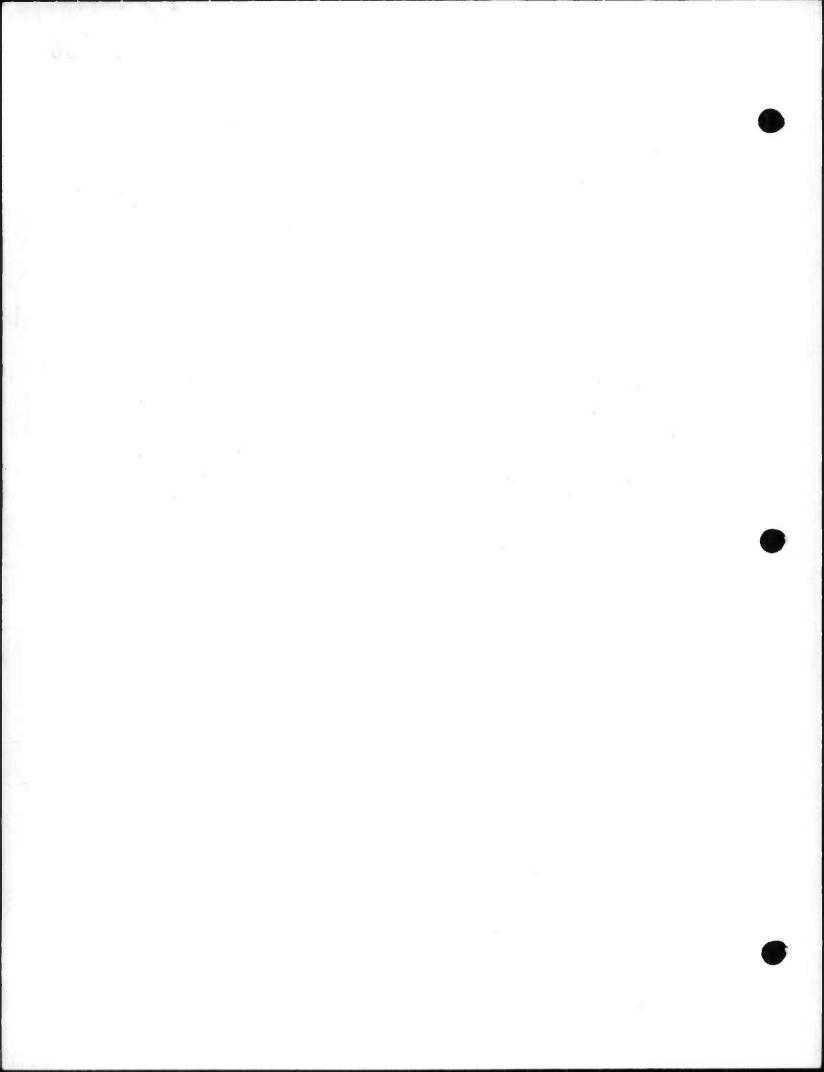
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State of Maryland / Department of Health and Mental Hygien 9 5 38329

						Certificate d		d Mentarriy	Reg. No.	30323					
н	Physic	ian	Decedent's Neme (First, Middle,	Last)				2. Dete of Dee Month		3. Time of Death					
	/Medi		DOROTHY L					DEC.	15, 19	95 6:30 am					
)	Exami	ner	4e. Fecility Neme (If not Institution,					or Location of Death							
			Meridian Herit				Dunda		Baltin						
	Funeral Director		215-48-4356		e (In yrs. last birt	frs. If Under 1 Ye Months De		Min. 8. Dete of Birth (Month, Da) Dec • 2	2,1911	Birthplace (State or Foreign Country) Pennsylvani					
	anyland show	-	Usuel Rasidence of Decedent 10a. Stete 10b. County		10c. City, Town					10d. Inside City Limits 1 ☐ Yes 2X No					
	rith tha M	Directo	Md. Balti 10e. Street and Number 1928 Queenswa		Dun	10f. Zlp Coo			10g. Citizen of Wha	it Country?					
50	be filed within 72 hours aftar death with the Maryland tial Hygiene. d other than "natural", or items 23a or 28a-f show event, the Medical Examinat must be notified at	/ Funeral Director	11. Meritel Stetus 1 □ Never Merried 2 ☒ Marrie	12. Was Decedent Armed Forcas?			of Hispanic Origin Cuben, Mexican, P	? (Specify Yes or No- uerto Rican, etc.)	14. Rece - Black, V	• American Indien, White, etc. White					
21215-0020	72 hours natural', dical Ex	eted by	3 Widowed 4 Divorced 15. Decedent's (Specify only highest	Yeer or Detes:		Decedent's Usuel Oc (Give kind of work do life. DO NOT use re		working	16b. Kind of Busin						
	al Hygiene. I other than "r vent, the Med	Completed	Elementery/Secondery (0-12) 12th	College (1-4or	5+)	life. DO NOT use re Homema	ker		Own Hor	me					
Maryland	Mal H	Be	17. Fether's Neme (First, Middle, La	1			0.400	Neme (First, Middle,							
2	and Mental a marked or umatic eve	P	Jacob Albert				Lydi	a	ticks	iller a set					
Ma	d 2 sh th and 7 la m traum		19e. informant's Name/Reletionshi					r Rural Route Numbe							
e,	s 1 and 2 should f Health and Mer tam 27 la marke other traumatic		Debbie Zimmer 20a. Method of Disposition	man	20b. Place of	Disposition (Neme of		rove Rd.	, Balto. 20c. Location - Cit	, Md . 21222 v or Town, Stete					
ō	agas ant of t: If h		XXBuriel 2 Cremetion 3		Meado	wridge N	olece) iem.Pk.	12-18-9							
Baltimore,	permit. Pagas 1 and 2 Department of Health is Important: If Itam 27 li any Injury or other tra once.		Meadowridge Mem.Pk. 12-18-95 Howard 21. Signeturi Funeral Service Licenses Bradley-Ashton Funeral Home, Ir 2134 Willow Spring Rd., Balto., N												
_			23e. Pert1. Enter the decase, or or	Value	Maria de la Danie	2134 Wil	low Sp:	ring Rd.	.Balto.	,Md.21222					
	Physician		shock, or heert failure. List or	nly one cause on each)	ne deeth. Do n	ot enter the mode of	dying, such es car	diac or raspiratory ar	rest,	Approximata interval Between Onset and Death					
	/Medical Examiner		Immediate Cause (Finel disease or condition resulting in death) Dua to (or as a consequence of):												
	outed ansit	Examiner	Sequentielly list conditions b. Chilowee Repart Heart Failure Le												
,09	ificate be asscuted g physician and as the burial-transit	al Ex	Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c. Col	7	74400100 017				5/2					
x 68760,	- Q1 W	Medical	resulting in deeth) Lest		Dué to (or es e co										
Box	attending for use a	lan		- 0.											
	y tha	Physician/M	Pert II. Other significant condition	contributing to death b	ut not resulting In	the underlying causa	given in Pert I.			bute to the cause of death? Probably 4 Unknown					
Vital Records P.O.	v requires that been signed b should be date	eted by		100 000				24a. Wes		4b. Wara eutopsy findings aveileble prior to completion of ceuse					
Rec	aw 2 s	Completed						101	es 2 No	of death?					
II a	delan: The	Be	25. Wes case refarred to medical exeminer?				26. Plece of	Deeth (Check only o	ne)						
5	Physic this ca al dire	7	1 ☐ Yes 2 ☐ No		ent 2 ER/Out			ng Home 5 Resid	ence 6 Other (Specify)					
Division of	or Attending Physician: after death. Director: After this cartific in by the funaral director,	ation:	27. Menner of Death 1 ☑Natural 5 ☐ Panding 2 ☐ Accident Investige				njury et Work? I ☐ Yes 2 ☐ No	28d. Describe h	ow Injury occurred						
DIV	is after de al Directo ed in by t	Certification:	3 ☐ Suicide 6 ☐ Could no datarmin		ury - At home, fer c. (Specify)	се	28f. Location (S City or Tow		or Rural Route Number,						
	To the Hospital or Attending Physician: The Iswithin 24 Junus after death. To the Funeral Director: After this cartificata ha completely filled in by the funeral director, page	edical		Physician: To the best of the basis of end menner sta	axaminetion end										
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SP. FACILITY NAME (if not institution, pive street and number) ST. ELIZABETH NURSING HOME BALTIMORE 10s. STATE		ND								MONTH	D.	19,1	995	3. TIME OF DEATH 7:30A
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S. DECEDENT'S USUAL OCCUPATION 180. KIND OF BUSINESS/ (Sport) on highest grade completed) 180. Construction of highest grade completed) 180. December 3 180. Decembe	DE /E	ECEDENT ES7 XI	AR OR D	ATES	RMED		If yes, sp	ecity Cube	ın, Mexican	, Puerto Ri	(Specify Yea			
HOBERT SUTHERLAND 196. NAFORMANT'S NAME (Type/Print) 196. NAFORMANT'S NAME (Type/Print) 120. NETHOD OF DISPOSITION 10. Burlet 2 Cremation 3 Removel from State 4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 12. SIGNATURE OF FUNERAL SERVICE LICENSEE 12. NAME AND ADDRESS OF FACILITY 12. SIGNATURE OF FUNERAL SERVICE LICENSEE 12. NAME AND ADDRESS OF FACILITY 12. SIGNATURE OF FUNERAL SERVICE LICENSEE 12. NAME AND ADDRESS OF FACILITY 12. SIGNATURE OF FUNERAL SERVICE LICENSEE 13. SIGNATURE OF FUNERAL HOME, INC. 14. OT WILKENS AVENUE—BALTIM 16. Sequentitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Finel disease or injury that intilated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): 28. MARCASE REFERRED TO MEDICAL EXAMBER? 1 DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH (YES NO UNCERTAIN NO VES 2 NO VES	r S	1-4 or 5 +)		16a. DE (G	Give kind of work done during most of working fe. Do NOT use retired.)									D. A. GMO. D.
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1 2 Suriet 2 Cremation 3 Removal from State Connection, Connection, Connection, Connection Connection Connection, Connection, Connection, Connection, Connection, Connection Connection, Con				19	1204 ELMRIDGE - BALTIMORE, MD 21229									
HUBBARD FUNERAL HOME, INC.	_	itate	cem L(OUDO	ematory or o	RK C	EMET	ERY		12/2				wn, State
23. PART I. Enfer the diseases, of complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory shock, or heart failure. List only one ceuse on each line. IMMEDIATE CAUSE (Finel disease or condition resulting in death) B. CONGESTULE TAILURE DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in deeth) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (O	00	26.	man			HI 4	JBBA 107	RD F WILK	UNERA ENS A	AL HO	E-BAL	TIMO	RE.M	D 21229
PART II. Other algnificant conditions contributing to deeth but not resulting in the underlying ceuse given in Part I. 24a. WAS AN AUTOPS PERFORMED? 1	TI	DUE TO (C	G F S (OR AS A (OR AS A	STUC	OUENCE OF	1 127 F): F):						ratory arr	• • • • • • • • • • • • • • • • • • • •	Approximate interval Batwonset and Do 12 yrs
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 2: 28. PLACE OF DEATH (Check only one) 28. PLACE OF DEATH (Check only one) 28. PLACE OF DEATH (Check only one) 28. PLACE OF DEATH (Check only one) 28. PLACE OF DEATH (Check only one) 29. Canceldent (Check only one) 28. PLACE OF DEATH (Check only one) 28. PLACE OF DEATH (Check only one) 28. PLACE OF DEATH (Check only one) 28. PLACE OF DEATH (Check only one) 28. PLACE OF INJURY (Month, Dey, Year) 28. DATE OF INJURY ON (Sirvet and Number of Injury of Town, Stete) 28. PLACE OF INJURY — At home, farm, street, factory, office 28. PLACE OF INJUR	PERFORMED? 1 YES 2 NO COMPLETION OF CA OF DEATH?												AMAILABLE PRIOR TO COMPLETION OF CAUS	
2 Accident Investigation M 1 YES 2 NO 1 Accident Accident						TH (Check	only one)	UNC	ERTAIN	123			\perp	
4 Homicide determined determined City or Town, Stete) 29e. CERTIFIER (Check only Certifying PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner as a	DEATH S Pending Investigation 1 Inpetient 2 ER/Outpatient 3 DOA 4 Mursing Home 5 R 28e. DATE OF INJURY (Month, Day, Year) 28e. INJURY WORK? M 1 YES 2 [NO	28d. DESC	RIBE HOW IP			Inutio Mumbor
O MEDICAL EXAMINER: On the beels of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to	t o	best of m	my knowl	ledge, de					, end due t	City or	Town, State)	ner as atat	ed.	
296. SIGNATURE AND TITLE OF CERTIFIER 29d. D	1	ne	ll	m	2			29c. LICE	ENSE NUME	BER		29d. DATI		(Month, Day, Year)



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

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						(Certificat	e oi	f Death			Reg. No.		
			1. Decedent'a Neme (First, Middle, L.	ast)							2. Dete of De	eth		3. Time of Deeth
	hysicl: /Medic		GUY	W.			STE	RL.	ING		DEC.	16 19	995	11:37AM
	xamin		4e. Facility Neme (If not institution, gi JOHNS HOPKINS						4b. City, To BALT		cation of Deeth	4c. Cour	ty of Deeth	A
100.00	neral ector		232-28-2519	Sex 110 M 2□ F	7. Age (In yrs. 78	lest birth	Months	1 Yea Dey		24 Hrs. Min.	8. Dete of Birt (Month, De FEB 26	h y, Year) 1917	9. Birthp Coun WEST	elece (Stete or Foreign stry) VIRGINI
ryland	in i		Usuel Residence of Decedent 10e. Stete 10b. County		10c. C	ty, Town	or Location						1	0d. tnside City Limits
e Ma	di di	Director	MD N/A	1		BALT	IMORE							YE Yes 2□No
£ 5	5 8	Dire	10e. Street end Number				10f. Zip					10g. Citizen o	f Whet Coun	itry?
the ct	Tale of		513 N. MILTO	_					205				S.A.	
Maryland 21215-0020 d 2 should be filed within 72 hours after deeth with the Maryland in and Mantal Hygiene.	imetic event, the Medical Examines must be notified at	by Funeral	11. Meritel Status 1 Never Merried 2 Married 3 Widowed 4 Divorced	If Yes, Giv	rces? 2□No19	12-			Hispanic Ori ben, Mexicar Specify:		ecify Yes or No Rican, etc.)	Spec	ace - Americ eck, White, ify: WH]	etc.
2-0-5-0-12-12-12-12-12-12-12-12-12-12-12-12-12-	Scal	eted	15. Decedent's E (Specify only highest gr			16a. C	ecedent's Usua Give kind of wo	ol Occi	upation	t of worki	na	16b. Kind of	Business/Inc	dustry
년 발 ·	Me	Completed	Elementery/Secondery (0-12)	College (1	-4or 5+)	7	ife. DO NOT u	se retir	red)					
Pol w Police	Ť.		8			AUT	OMOBII	ĿΕ	T				MOTIV	Έ
De fi	200	Be	17. Fether's Neme (First, Middle, Las						18. Mothe	ers Neme	(First, Middle,	Meiden Sume	em e)	
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	othe	ŀ	THERESA A. KEM 20e. Method of Disposition	MER	20b.		3 N. No Disposition (Ner		TON A	VE.	, BALT	20c. Location		
Baltimore, bemit. Peges 1 er Department of Hea	0.0		1 ☐ Buriel 2 ☐ Cremetion 3		Stete	cemetery,	cremetory or o	ther pi						,
Baltim permit. Peg Department	any injury or once.	-	4 Donetion 5 Other (Specify) CHESAPEAKE CREMATORY 12-19 BELTSVILI 21. Squartup of Eyneral Service Licensee 22. Name and Address of Facility											, MD
Balt Pemit.	any le		> Hullys X	Harte	2		MORAN 3000	I-A E.	SHTON BALT	FUI IMOI	NERAL RE ST.	, BAL	INC.	ID 21224
			23a. Pert1. Enter the disease, or con shock, or heart feilure. List only	plications thet co one cause on e	aused the dee ech line.	th. Do no	t enter the mod	e of dy	/ing, such es	cardlec o	or reaplretory as	rest,		Approximete Interval Between
Physi /Med Exam	dical		Immediate Cause (Final disease or condition resulting in death)	Arte			tic Ca		iovas	cula	ar Dis	ease	1	Onaet and Deeth
70	=	ner			500101	01 00 0 00	risoquerioa ory.							
68760, ifficate be executed	e es the buriel-transit	i Examiner	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury C.											
ox 68760,	use es the	n/Medical												
	o p	Icla	Pert II. Other significant conditions	contribution to de	ath but not res	ulting in t	he underlying c	ausa n	iven in Pert I		23h Did i	obacco use c	ontribute to	the cause of death?
	detached	Physician/												oably * Unknown
S the		by	Chronic Obstr	uctive	Pulmo	nar	y Dise	ase	e					
Cord	2 should	Completed										an eutopsy rmed?	ava	ere autopsy findings allebie prior to mpletion of cause death?
Z 2	page	PO.									101	res 25 No	*]Yes 2□ No
Vital Iclan: Th	director, page	Be	25. Wes case referred to medical examiner?						28. Place	of Deeth	(Check only o	ne)	1	
Of V Physics		2	1 Yes 2 No	1		ER/Outp	etlent 3 DC	A O	ther: 4 🗆 Nu	ursing Hor	me 5□ Resid	dence 6 🗆 O	ther (Specifi	v)
DIVISION OF VITA or Attending Physician: after death. Director: After this cardition			27. Menner of Deeth 1 ☑ Neturel 5 ☐ Pending 2 ☐ Accident Investigation	n	of Injury h, Dey Year)	28b. Tin Inji	ne of 2	8c. Inj W 1 [ury et ork? □ Yes 2 □		28d. Describe I	now Injury occ	urred	
DIVI	2	Certif	3 ☐ SuicIde 4 ☐ HomIcIde 6 ☐ Could not be determined 28e. Plece of Injury - At home, ferm, street, factory, offica building, etc. (Specify)								28f. Location (S City or Tox		n <i>ber</i> or Rura	i Route Number,
To the Hospital within 24 hours	completaly filled in	edical	29e. Certifier (Check only one) 1 ☐ Cartifying Pi		isls of exemine									
To t	E CO	Σ	29b. Signeture and title of certifier 29c. License number 29d. Date signed (Month,											Dey, Year)
			Wonald J. Wright MD O.C.M.E. DECEMBER 16, 1995 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)											6,1995
-	CA		Donald G. Wri	ght M.I	D. 111	Pe	nn Str	ee	t, Ba	ltim	more,	Maryla	and 2	1201
Re	Stat egistra		DEC2 0 t	995	gistretis Sign	er l	well							

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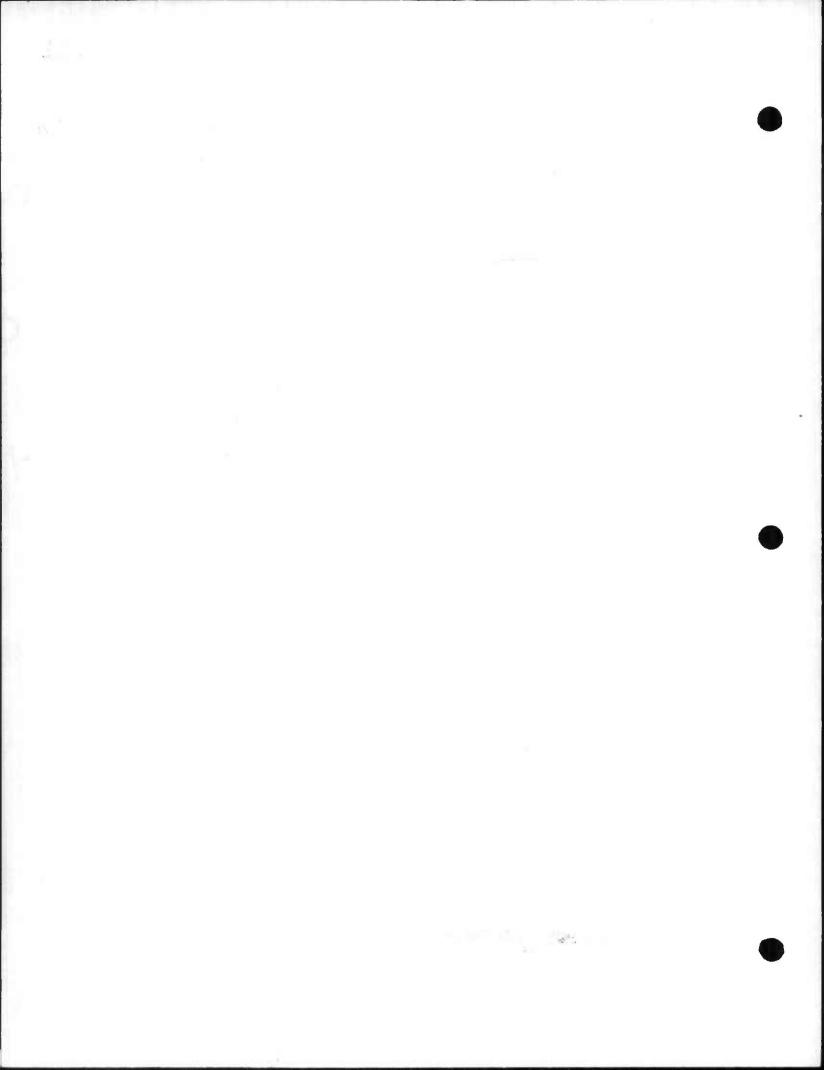
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BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within and hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNKERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burrial, cremation, or removal.	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at onee.
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	ITEMS: 10e, PER F.H. 26 PER FACILITY FI	LM G-73	30 12/20/95	i t.t		9	5 38332						
	1 STATE OF MARYLAND	/ DEPAR		EALTH AND I	MENTAL HYGI								
	1. DECEDENT'S NAME (First, Middle, Level)				2. DATE OF DEATH MONTH Detember	DAY	YEAR 3. TIME OF DEATH						
	4. SOCIAL SECURITY NÚMBER 5. SEX 8. AGE (In yrs. 044-48-1319 1½ M 2 🗆 F 40	last birthday) YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year Apr. 6, 1		8. BIRTHPLACE (State or Foreign Country) Connecticut						
TOR	98. FACILITY NAME (If not institution, give street and number) Johns Hopkins Bayview Med RESIDENCE OF DECEDENT	Ctr		imore			UNTY OF DEATH N/A						
DIRECTOR	10a. STATE 10b. COUNTY Maryland N/A	10c. CIT	Y, TOWN OR LOCAT				10d, INSIDE CITY LIMITS? 1 💢 YES 2 🗌 ND						
FUNERAL	100. STREET AND NUMBER 4409 WAKEFIELD ROAD 5200 Eastern Avenue	1	101	21216		10g, CIT	TIZEN OF WHAT COUNTRY?						
BY	3 Wildowed 4 Divorced 6/6/79 11/28/79												
COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th 15. DECEDENT'S EDUCATION (Specify only highest grade completed) 16a, 16a,	(Give kind of a life. Do NOT us	USUAL OCCUPATION Work done during mose retired.)	ON st of working	16b. KIND OF								
OM	17. FATHER'S NAME (First, Middle, Last)	Idi	HUCL	16. MOTHER'S NAI	ME (First, Middle, Maid	ion Sumama)							
w	Charlie J. Tyson			- 11	rie Alle								
TO B	19a. INFORMANT'S NAME (Type/Print) Charlie J. Tyson				ad, Bal		(p Code) (e,MD 21216						
	20s. METHOD OF DISPOSITION 1 Serial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	CEAND DATE	of Disposition (Na ther place) Forest	11/2: Vet.	1 DATE 20c.		City or Town, State						
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE	1	22. NAME AN	ID ADDRESS OF FAC	CILITY		NERAL HOME						
	Service, Duct		4600	LIBERT	Y HEIGH	rs AV	ENUE 21207						
	23. PART if Enter the disease, for complications that desired the death. Do not enter the mode of dying, such as cardisc or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death disease or condition												
	nesulting in death) a. Due To (or As A cont	BEDUENCE OF	Inter	Saus									
ATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING	SEQUENCE OF					(C) CAV						
ERTIFICATION	CAUSE (Disease or injury that initiated events resulting in death) LAST	SEDUENCE OF	F):										
O	PART II. Other significent conditions contributing to deeth but no	t resulting	in the underlying	cause given in i	Part i. 24a WAS	AN AUTOPSY	24b. WERE AUTOPSY FINDINGS						
PHYSICIAN: MEDICAL						ORMED?	AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?						
Σ.	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DE	ATH YE	S NO	UNCERTAIN			1 TES 2 NO						
CIA	EXAMINER? HOSPITAL:	ACE DF DEAT	TH (Check only one) OTHER:										
14S	1 ☐ YES 2 ☐ NO 1 1 ☐ Inpatient 2 ☐ ER/Outpatient 27. MANNER OF DEATH 28s. DATE OF INJURY		4 - Nursing Home	5 Residence									
ВУ Р	1 Netural 5 Pending (Month, Day, Year) 2 Accident Investigation		M 1 Y	RK? 'ES 2 ND	28d. DESCRIBE HO								
ETED	3 Suicide 6 Could not be 4 Homicide 6 Could not be determined	nome, rarm, s	erreet, factory, office		City or Town, Sta	et and Number rte)	or or Rural Route Number,						
COMPLE	29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, one) 2 MEDICAL EXAMINER: Dn the basis of examination and/o												
ш	296. SADNATURE AND TITLE OF CERTIFIER			29c, LICENSE NUM			TE SIGNED (Month, Day, Year)						
TO B	folial & MD			1840	14		cember 18, 1995						
			Print) Hiple	in the	spital								
	31. DATE FILED (Month, Day, Year) DEC 2 0 1995 July Day Office of Control of	ardall	a.										

31. DATE FILED (Month, Day, Year)
DEC 2 0 1995



DALI INORE, INAU LAND	hours after death. Page 6 may be retained	ed in by the funeral director, page 5 should t	or removal.	medical examiner must be notified a	
	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hosp	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detache	be filed writhin 72 hours after death with the State Dept. of Health and Mental Hyglene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	

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	1 - FOR STATE REGISTRAR	OF MARY	LAND / DEPA CERTII	RTMEN	TOF H	EALTH AND I	MENTAL	HYGIEN					
	DECEDENT'S NAME (First, Middle, Last) WAYNE.	EDWARD) WRIGHT	r			2. DATE (MONTH DECEM		AY 5 1	YEAR	3. TIME OF DEATH 4 • 5 5 PM M		
	4. SOCIAL SECURITY NUMBER 5. SEX 219-26-7972 1 ☑ M 2	6. AGE	7 YRS.		ER 1 YEAR	IF UNDER 24 HRS. HOURS MIN.	7. DATE ((Month)	DE BIRTH Day, Year) CH 8,1		8. BIRTH Countr	IPLACE (State or Foreign		
OR	Sa. FACILITY NAME (# not institution, give street and num ST. AGNES HOSPITAL	ber)		9b. Cl		R LOCATION OF DE LTIMORE	EATH		BALTIMORE CITY				
DIRECTOR	RESIDENCE OF DECEDENT 10a. STATE MARYLAND BALTIMOR	RE CITY		DE. CITY, TOWN OR LOCATION BALTIMORE							10d. INSIDE CITY LIMITS?		
FUNERAL I	100. STREET AND NUMBER 3149 STAFFORD STREET	0111	l	101. ZIP CODE 21229					1 📉 YES 2 🗌 NO WHAT COUNTRY?				
BY	11. MARITAL STATUS 12. WAS DI 1 Never Married 2 Married 17 Married 17 Married 18 Married 19 Married	IN U.S. ARMED 5 2 NO DATES -5-26-59	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify II yes, specify Cuban, Maxican, Puarto Rican, etc.) 1 YES 2 NO Specify:						S . A . 14. RACE Black Species	E — American Indian, k, Whita, atc.			
COMPLETED	18. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 1 2 TH College (1)	16a. DECEDENT (Give kind of life. Do NOT SUPERV	work don	e during mos !.)	N t of working		OR CO						
BE CON	17. FATHER'S NAME (First, Middle, Last) UNKNOWN WRIGHT				16. MOTHER'S NA HELEN	ME (First, M		Surname) NOWN					
TO E	19a. INFORMANT'S NAME (Type/Print) DENISE ARNOLD		19b. MAILIN 2905	ILINO ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5 LOUISANNA AVENUE - BALTIMORE, MD 21227							21227		
	20e. METHOD OF DISPOSITION 1 N Burlal 2 Cremation 3 Ramoval from St 4 Donation 5 Other (Specify)		b. PLACE AND DATE				12/1		CATION - ALTII	City or To	wn, Stata		
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE	man	/	H	UBBAR	D ADDRESS OF FA	AL HO	-		DE N	D 21229		
	23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory errest, shock, or heart feiture. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF):										Approximate Interval Between Onset and Death		
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):												
	PART II. Other significant conditions contribut	ing to death	but not resulting	in the u	underlying	cause given in	- 1	24s, WAS AN PERFOR	MED?	24b.	WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO		
PHYSICIAN: MEDICAL	DID TOBACCO USE CONTRIBUTE TO 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO	AL: , A	k only one)	UNCERTAIN	A								
BY PHYS	1 YES 2 NO 1 Inpetta 27. MANNER OF DEATH 28a. D (h) 1 Natural 5 Pending (h) 2 Accident Investigation	petlent 3 DOA	_	28c. INJU WOR	K?		(Specify)	NJURY OC	CCURED				
	3 Suicide 8 Could not be detarmined	LACE OF INJURY allding, etc. (Spe	Y — At home, larm,	street, fa	ctory, office			TION (Street a		r or Rural R	loute Number,		
COMPLETED	29e. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the one) 2 MEDICAL EXAMINER: On the be-										and manner as stated.		
IO BE C	296. SIGHAYURE AND TITLE OF CONTINUER SO MAN AND ADDRESS OF BERNOON AND	M				29c. LICENSE NUM D 3854					(Month, Day, Year) BER 18, 1995		
	KEVIN H. SCRUGGS MID GOV CATON AVENUE BALTIMURE, MARYLAND 21229										21229		



KEVIN H. SCRUBES

31. DATE FILED (MORTH, Day, Year)

DEC 2 0 1995 July

32. REGISTRAR'S SIGNATURE

Salvador"

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- 1	1. DECEDENT'S NAME (First,		2. DATE OF DEATH DAY YE			3. TIME OF DEATH							
	Jean Olea Wilkerson ALLEN 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. least birthday) IF UNDER 1 YEAR IF UNDER 24 MRS. 7. DATE OF BURTTY										r 4. 1995 12:35		
	MONTHS DAYS HOUSE MAN									Month, Day, Year)	005	Countr	
	90. FACILITY NAME (# not in:		43	70	ins.	9h CITY TI	DWN O	R LOCATION		eb. 16,1	_	Was	hington,D.
DIRECTOR												Georges	
E	10a. STATE	10b. COUNTY	1		10c. CITY	Y, TOWN OR	LOCATI	ON					10d, INSIDE CITY
5	Maryland	Prince	e Georges	3	Ade	elphi							LIMITS?
FUNERAL	10a. STREET AND NUMBER						101.	ZIP CODE			10g. CIT	IZEN OF Y	VHAT COUNTRY?
崱	8307 Curry				20783	3		Un	ited	States			
BY FU	11. MARITAL STATUS 1 Never Married 2 X 3 Widowed 4 Divo	ARMED	If y	es, spe	NDENT OF I	Mexican, Pu	RIGIN? (Specify Yea erto Ricen, atc.)	or No—	14. RACE Bleck Speci	— American Indien, c, White, stc.			
E0 B		270											Black
ETE	(Specify only	EDENT'S EDUC highest grade	completed)		(Give kind of w	voric done duri	UPATION ing mos	N t of working		166. KIND OF BU	SINESS/INI	DUSTRY	
2	Elementary/Secondary (0-12) College (1-4 or 5+) 5+ Teacher Public School									1 -			
COMPL	17. FATNER'S NAME (First, MI	iddle, Last)	J.		reacile	-1	I	16. MOTNER	I'S NAME /F	PUDILC irst, Middle, Meiden		0018	
w I	William Hen	ry Wil	lkerson							Frankli			
0	19. INFORMANT'S NAME (7)	19b. MAILING	ADDRESS (S	Street an			Number, City or Tow		o Code)				
F	Willie C. A	llen			8307 (Curry	Pla	ace, A	delp	hi, Mary	land	2078	33
	20e. METNOD OF DISPOSITE 1 M Burlei 2 ☐ Cremation	ON n 3 🗆 Remo	oval from State	20b, PLAC	ON (Nan	ne of	DATE 20c. LOCATION City or Town, State						
	4 Donation 5 Other	(Specify)	-	Line	oln Me					3/95 Sui	tlan	d, Ma	aryland
- 1	21. SIGNATURE OF FUNERAL	E BERVICE LIC	Mr 1	7	· en			ADDRESS			T		
	McGuire Funeral Service, Inc. 7400 Georgia Ave. N.W., Washington, D.C. 23 PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate												
	23 PART I. Enter the di- shock, or he	seases, or c	omplications tha	caused the	death. Do n	ot anter th	e mod	a of dying	, such as	cardiac or reapi	ratory an	reat,	Approximata
1	IMMEDIATE CAUSE (Final											Interval Between Onset and Dea	
	resulting in death)											umen	
	DUE TO (OR AS A CONSEQUENCE OF):										1.		
5	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury C.C.) DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): C										erou	a zwell	
Ę	If any, leading to immediate cause. Enter UNDERLYING											3 insel	
Ĭ	CAUSE (Disease or Injur that initiated events		DUE TO	OR AS A CON	SEQUENCE OF):							1300
CERTIFICATION	resulting in death) LAST	' (a	1										
<u> </u>	PART II. Other algnificat	nt conditions	a contributing to	death but no	ot resulting in	n the unde	rivina	cause give	en in Pert	1. 24a, WAS AN	AUTOREY	245	WERE AUTOPSY FINOING
MEDICA							,	outso give		PERFOR	MED?	- 240.	AWAILABLE PRIOR TO COMPLETION OF CAUSE
										1 TYES 2	THO		OF DEATH?
- 10	DID TOBACCO US	SE CONTR	RIBUTE TO CA	USE OF DE	EATH YE	s \square NO) [Zł	LINCER	TAIN [1			1 YES 2 NO
Š	25. WAS CASE REFERRED TO				ACE OF DEAT			0110211		-1			
SICIAN	EXAMINER?		HOSPITAL:	ER/Outpatient	3 DOA	OTHER:	Home :	5 🗆 Reald	ence 6 🗆	Other (Specify)			
Ē	27. MANNER OF DEATH	OF AURT	28a. DATE OF (Month, Di		28b. TIME	OF 28	c. INJU	RY AT		DESCRIBE NOW II	JURY OC	CURED	
		Pending nvestigation	1,000	0.037				ES 2 N	0				
\ I		Could not be	28e. PLACE O building,	F INJURY — At etc. (Specify)	home, farm, st	treet, factory,	, office		281.	LOCATION (Street a City or Town, Stete)	nd Number	or Rural A	loute Number,
		letermined											
			CIAN: To the best of										
	2 MEDIC	CAL EXAMINER	: On the beels of er	amination end/	or investigation	n, in my opin	lon, de	eth occured	at the time,	date end place, en	d due to th	ne ceuse(e)	end manner ee stated.
OMPLETE								29c. LICENS	E NUMBER		29d. DAT	E SIGNED	(Month, Pay, Year)
E COMPL	296. SIGNATURE AND TITCE	OF CERTIFIER	(/ _	140						- Total Date:			
BE COMPL	29b. SIGNATURE AND TITCE	Mu	mit	no				DI	175	12	>	12/	5/95
BE COMPL		Mu	mit	E OF DEATH (I			0	DI Los	175	12	>	72/3	5/95
BE COMPL	29b. SIGNATURE AND TITCE	PERSON WHO MITE	COMPLETED CAUS	E OF DEATH (I	Hera	Print)	8	ree	450	17, 1	P	20	770
TO BE COMPLETE	29b. SIGNATURE AND TITCE	Mu	mit	E OF DEATH (I				DI	175	12		12/3	5/95

Delv - G

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 54 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1. 2. 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

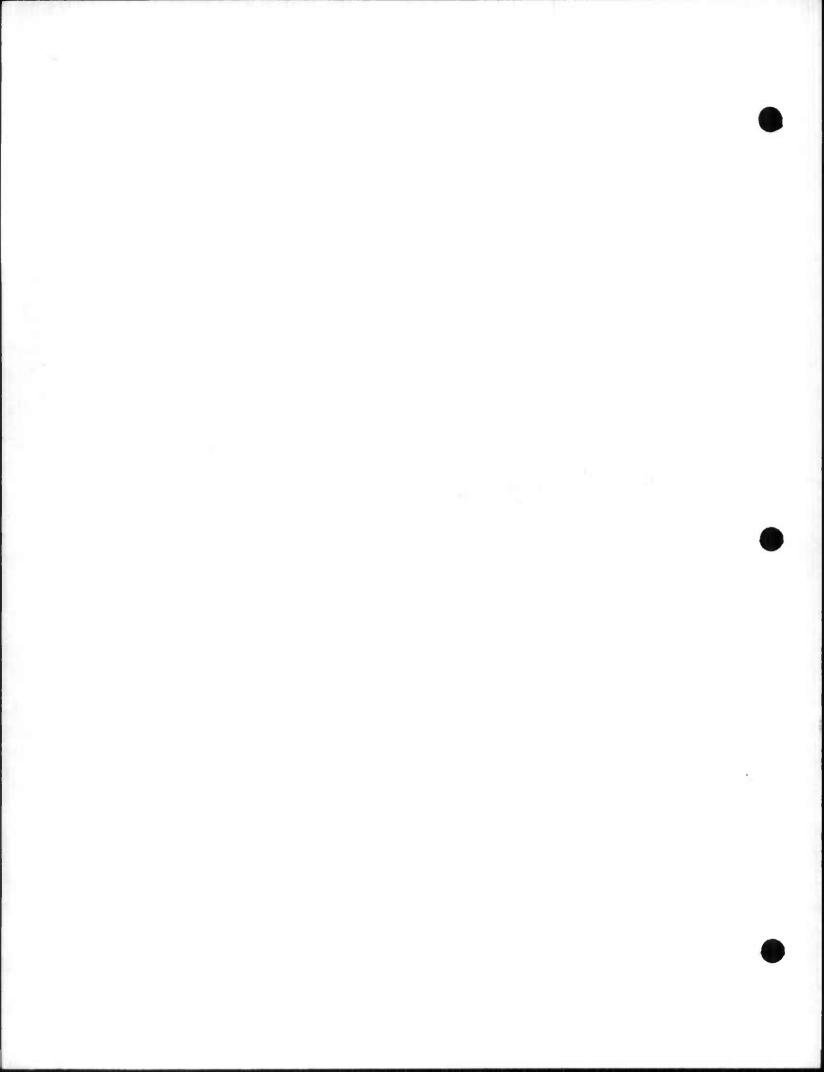
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

1 - STATE

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAR				CERTIF	ICAL	E OF	DEA	I H		REG. NO												
	1. OECEDENT'S NAME (First, Middle	,	. 1							2. DATE OF MONTH	DEATH D	AY	YEAR	3. TIME OF DEATH									
			eth And			,				Decem				5:00 Am									
	4. SOCIAL SECURITY NUMBER		5. SEX	6. AGE (In yrs.		WONTHS	DAYS	HOURS	24 HRS.	7. DATE OF (Month, D			8. BIRTH Count	IPLACE (State or Foreign									
	226-42-7311		1 □ M 2 😾 F	88	YRS.					July	28,1	907	Ind	liana									
~	9a. FACILITY NAME (If not institution	n, give stree	et and number)			9b. CIT	Y, TOWN (R LOCATI	ON OF DE	ATH		9c. CO	UNTY OF D	EATH									
Ď.	Bedford Court		Si	lver	Spri	ng			Mon	tgome	ery												
2		COUNTY			10c. CIT	Y, TOWN	OR LOCAT	ION						10d. INSIDE CITY									
FUNERAL DIRECTOR	Maryland Montgomery					Silver Spring							LIMITS?										
₹.	10e. STREET AND NUMBER		101. ZIP CODE								VHAT COUNTRY?												
W	3700 Internati					20906							States										
3	11. MARITAL STATUS 1 Never Married 2 Marrie	11. Marital Status 12. Was Decement every FORCES? 1 Name Marital				NO If yes, specify Cuben, Mexican, Puerto Rican, etc.)				14. RACI Black	- American Indian, c, White, atc.												
ВҰ	3XXWidowed 4 Divorced		IF YES, GIVE W	AR OR DATES			1 TYES	2√□ NO	Specify				Speci	White									
COMPLETED	15. DECEDENT (Specify only highe	'S EDUCAT	TION	16a.	DECEDENT'S	USUAL O	CCUPATIO	ON .		16b. KII	ND OF BUS	SINESS/IN	DUSTRY	MILLEE									
E	Elementary/Secondary (0-12)		College (1-4 or 5 +	,	(Give kind of life. Do NOT u	work done se retired.)	during mo	st of working	g														
P			5+		Teacher			Education															
Ö	17. FATHER'S NAME (First, Middle, L	ast)						18. MOTI	IER'S NA	ME (First, Midd	lle, Melden	Sumame)											
BE	Leslie St	oner						A	nna	Best													
10	19e. INFORMANT'S NAME (Type/Pris	nt)			19b. MAILING	ADDRES	S (Street e	nd Number	or Rural F	Route Number,	City or Tow	n, State, Zi	ip Code)										
F	Doris Ann Rose	nfie	ld		11603	Debo	orah	Driv	e, F	otoma	c, Ma	aryla	and	20854									
	20e. METHOD OF DISPOSITION 1 Burlei 2 (2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Montgomery Crematorium, Inc. Bethesda, Mary									wn, State													
										ryland													
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY ROBERT A PIMPIN PROVIDENCE AND ADDRESS OF FACILITY ROBERT A PIMPIN PROVIDENCE AND ADDRESS OF FACILITY ROBERT A PIMPIN PROVIDENCE AND ADDRESS OF FACILITY ROBERT AND ADDRESS O								ev Funeral														
	M00348 Wisconsin Ave., Bethesda, Maryland								7557 nd 20814														
	23. PART i. Entar the disease ahock, or heart for	m, or con	npilcations that	caused the	daath. Do i	not antar	tha mo	de of dy	ng, sucl	n as cardiac	or reapl	ratory ar	rreat,	Approximate									
	IMMEDIATE CAUSE (Final	mure. Lie	of only ona cau	se on aech i	ina.									Interval Between Onset and Death									
	disease or condition Coronary Artery Disease										Years												
Ì	OUE TO (OR AS A CONSEQUENCE OF):											rears											
Z	Sequentially list conditions, Congestive Heart Failure Months																						
CERTIFICATION	Sequentially list conditions, If any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF):																						
2	CAUSE (Disease or injury	۵.																					
늗	that initiated events		DUE TO	OR AS A CON	SEQUENCE O	F):																	
8	reading in death, Exor	d																					
	PART II. Other significant cor	nditiona d	contributing to	dasth but no	t resulting	in tha ur	ndariying	cause o	Iven in	Part I. 24	. WAS AN	AUTOPSY	24b	WERE AUTOPSY FINDINGS									
EDICAL	Dementia - y										PERFOR			MAILABLE PRIOR TO COMPLETION OF CAUSE									
	Bleeding ulc	erg	- months	c						- ''	YES 2	NO S		OF DEATH?									
Σ	DID TOBACCO USE C				FATH VE	s \square i	NO F	LINC	EDTAIN	UE			Ш	1 TYES 2 X NO									
Ž	25. WAS CASE REFERRED TO MEDI		JOIL 10 CA		ACE OF DEA			UNC	CKIAII	4 871													
Sic	EXAMINER? 1 YES 2 NO		OSPITAL:	FR/Outpatient	3 DOA	OTHER	R:		aldanas	6 Other (Sc													
PHYSICIAN:	27. MANNER OF OEATH		28e. DATE OF	INJURY	28b. TIM	E OF	28c. INJ	JRY AT	stoence	28d. OESCRI		NJURY OC	CURED										
	1 Natural 5 Pendin		(Month, Da	ty, Ybar)	INJ	URY	1 Y	RK7	NO														
BY	2 Accident Investig 3 Suicide 6 Could		28e. PLACE OF	F INJURY — At	home, farm,	treet, fact				261. LOCATIO	N (Street e	nd Numbe	r or Rural R	bute Number									
밀	4 Homicide determi		building,	etc. (Specify)					- 1	City or To	wn, State)												
ا ۳	29e. CERTIFIER (Check only	PNYSICIA	N: To the heat of	my knowledge	death occurr	ad ad the t	les data	and alass			. Ne.V												
COMPLET														end manner es stated.									
	29b. SIGNATURE AND TITLE OF CE					.,, .	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				piace, en	000 10 1	ne cause(s	and manner es stated.									
H	200 011	()		,				29c. LICE	NSE NUM	BER				(Month, Day, Year)									
2	30. NAME AND ADDRESS OF PERS		avella	E OF DEATH #	TEM OF IT	D-i-di		H 4	1/	13			Decem	ber 2, 1995									
							ona1	Driv	re, S	Silver	Spr	ing,	MD 2	0906									
											-			Martha S. Saavedra, M.D., 3701 International Drive, Silver Spring, MD 20906									
	31. DATE FILED (Month, Day, Year)	-	32. REGISTRAN	T'S SIGNATURE	E .																		



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Jeremy V.

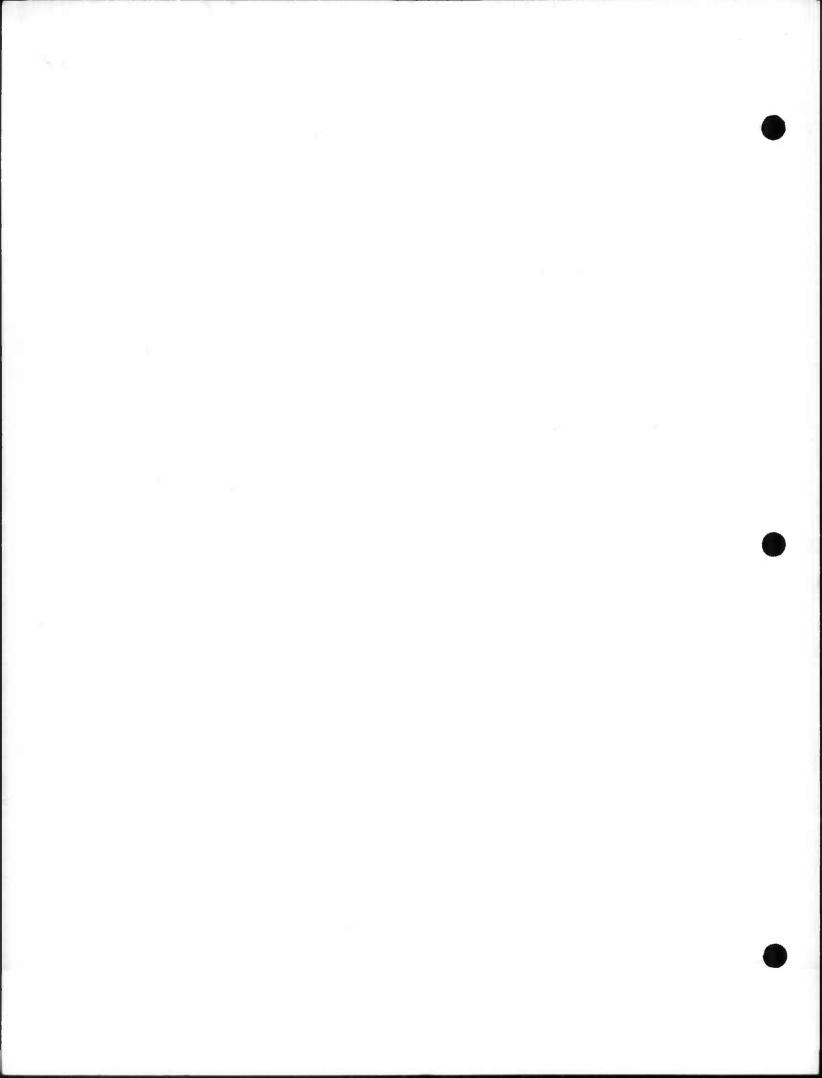
08 1995

Cooke, M. D.,

SE RECUSTRAN'S SIGNATURE

Amended #24a, 12/8/95, JW, Montgomery County FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH 3. TIME OF GEATN Michael Ames - Cocharo December 4 1995 5:25 A 7. DATE OF BIRTH (Month, Day, Year 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. lest birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. DAYS HOURS 156-01-2383 1 X M 2 - F 73 Oct. 2, New Jersey Pages 1, 2, 3 should 9e. FACILITY NAME (If not institution, give street end number, 9b. CITY, TOWN OR LOCATION OF DEATN 9c. COUNTY OF DEATH DIRECTOR Suburban Hospital Bethesda Montgomery RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Montgomery Wheaton permit. 1 - YES 2 X NO 10e. STREET AND NUMBER FUNERAL 101. ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? detached for use as the burial-transit 11508 Highview Avenue 20902 United States retained by the hospital or attending physician. 13. WAS OECENDENT OF NISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. MARITAL STATUS 12. WAS DECEDENT EYER IN U.S. ARMED FORCES? 1 V YES 2 NO IF YES, GIVE WAR OR DATES 14. RACE — American Indian, Black. White, etc. If yes, specify Cuben, Mexican, Puerto Ric 1 Never Married 2 Merried BY 3 Widowed 4 Divorced WW II White COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16a. OECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY Self-employed nentary/Secondary (0-12) College (t-4 or 5+) 12 Ames Associates, Inc. Personnel Consultant once. 17. FATNER'S NAME (First, Middle, Last) 16. MOTNER'S NAME (First, Middle, Meiden Surname) director, page 5 should be Ti Guiseppe Cocchiaro BE Rosina Nappe notified 19e. INFORMANT'S NAME (Type/Print) 19b. MAILINO ADDRESS (Street end Number or Rural Route Number, City or Town, State, Zip Code) 5 Mildred S. Ames Same as 10 hours after death. Page 6 may be pe 20b. PLACE AND DATE OF DISPOSITION (Name of OATE 20c. LOCATION - City or Town, State must Chesapeake Crematory or other place; Chesapeake Crematory 12-8 Beltsville, Maryland examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Rapp Funeral Services, P. A. ellex 933 Gist Avenue, Silver Spring. nding physician and completely filled in by the Hygiene prior to burial, cremation, or removal. MD 20910 traumatic event, the medical 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, ahock, or heart failure. List only one cause on each line. interval Between Onset and Death **IMMEDIATE CAUSE (Fine)** 24 disease or condition reaulting in death) no DUE TO (OR AS A CONSEQUENCE OF): CERTIFICATION Sequentielly list conditions, OUE TO (OR AS A CONSEQUENCE OF if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury other OUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in deeth) LAST 0 Mental PART II. Other algnificant conditions contributing to death but not resulting in the underlying ceuse given in Part i. MEDICAL 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS certificate has been signed by in the State Dept. of Health and AVAILABLE PRIOR TO shows any COMPLETION OF CAUSE 1 YES 2 NO PHYSICIAN: 8 25. WAS CASE REFERRED TO MEDICAL Item . 26. PLACE OF DEATH (Check only one) **EXAMINER?** HOSPITAL: OTHER: 1 TES 2 DEMO 1 Sinpatient 2 ER/Outpatient 3 DOA ne 5 🗆 Residence 8 🗀 Other (Specify) 0 28e. DATE OF INJURY (Month, Day, Year) 27. MANNER OF DEATH 28b. TIME OF 28c. INJURY AT WORK? 28d. OESCRIBE NOW INJURY OCCUREO With is marked, 1 Neturel 5 Pending Investigation t YES 2 NO BY death 2 Accident DIRECTOR: After 28e. PLACE OF INJURY — At home, ferm, street, factory, office building, etc. (Specify) 3 Suicide 8 Could not be 281. LOCATION (Street end Number or Rural Routs Number, City or Town State) COMPLETED hours after 28 4 Nomicide Hem 29e. CERTIFIER (Check only CERTIFYINO PNYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) and menner as stated. THE HOSPITAL (THE FUNERAL D filed within 72 h TO THE FUNERAL IDE filed within 72 h 2 MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(e) and menner ee stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d, DATE SIONED (Month, Day, Year) sole 12 no YC 2 30. NAME AND ADDRESS ON PERSON WHO COMPLETED CAUSE OF DEATN (ITEM 27) (Type, Print)

10400 Connecticut Avenue, #606, Kensington,



P.O. BOX 68760 DIVISION OF VITAL RECORDS,

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31 DATE FRED AN

04 1995

FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REGISTRAR CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH 3. TIME OF DEATH 1995 ISABELLE AMOS NOLA November | 30 8:45 PM A SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreig Sept 5, 215-34-0762 DAYS 1 M 2 X F HOURS Maryland 1912 9e. FACILITY NAME (If not institution, give street end number) 9b. CITY, TOWN DR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Pages 1, 2, 3 3601 Marpat Drive Abingdon Harford 10b. COUNTY 10c. CITY, TOWN DR LOCATION 10d. INSIDE CITY Maryland
100. STREET AND NUMBER Harford Edgewood 1 YES 2 X ND Dermit. FUNERAL 10f. ZIP CODE 10g, CITIZEN DE WHAT COUNTRY? funeral director, page 5 should be detached for use as the burial-transit 2913 Willoughby Beach Road 21040 USA retained by the hospital or attending physician. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ABMED FORCES? 1 YES 2 NO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuben, Mexican, Puerto Ricen, etc.)

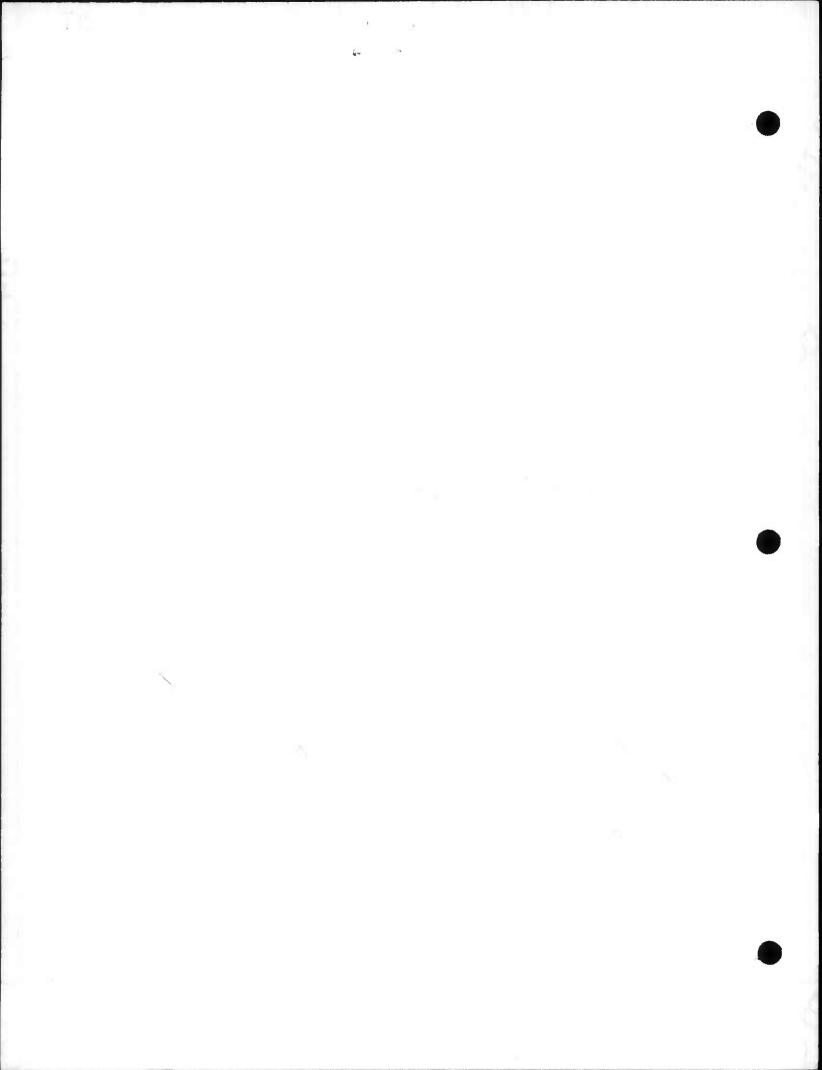
1 YES 2 NO Specify: 14. RACE — American Indian, Black, White, etc. BALTIMORE, MARYLAND 21215-0020 Never Married 2 Married IF YES, GIVE WAR DR DATES BY 3 Widowed 4 Divorced White COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complet 16e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY College (1-4 or 5 +) Homemaker Home once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Henry (nmn) Cage Ada Belle Wilson BE notified 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street end Number or Rural Route Number, City or Town, State, Zip Code) 2 Mrs. Helen Sylvester 1809 Larch Drive, Edgewood, Maryland 21040 Раде 6 тау be 9 20a METHOD DF D SPOSITION
1 M Burlel 2 Cremetion 3 C
4 Donation 5 C Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State DATE must comejery crematory or other place)
Cokesbury U.M. Cemetery 12-4-95 Abingdon, Maryland examiner 22. NAME AND ADDRESS OF FACILITY
HOWARD K. McComas III Funeral Home after death. 1317 Cokesbury Road, Abingdon, Md. npletely filled in by the cremation, or removal. 21009 medical or compfications Wat coused the deeth. Do not enter the mode of dying, auch as cerdiac or reepiratory arrest, Approximata shock, or heart failure. Liaj only one cause on each line. Intervel Between MEDIATE CAUSE (Finel **Onset and Death** cremation. the ease or condition BUIC 40, naulting in death) traumatic event. requires that the death certificate be executed with DUE TO (OR AS A CONSEQUENCE OF) hysician and com COM CERTIFICATION Sequentially list conditions, DUE TO (DR AS A CONSEQUENCE OF): attending physician a antal Hygiene prior to if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury other DUE TO (OR AS A CONSEDUENCE DE) that initiated events resulting in death) LAST 6 signed by the atter Health and Mental PART II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO PHYSICIAN: MEDICAL any PERFORMED? COMPLETION DF CAUSE OF DEATH? Shows 1 YES 2 ND been : DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN has be Dept. HOSPITAL OR ATTENDING PHYSICIAN: The law 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) this certificate h Item HOSPITAL OTHER:
4 | Nursing Home 5 Hasidence 6 | Other (Specify) G PHW JAYPH BYC S 1 YES 2 ND 1 Inpetient 2 ER/Outpetient 3 DOA 0 27. MANNER OF DEATH 26s. DATE DF INJURY (Month, Day, Year) 26b. TIME OF INJURY 26c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED marked. 1 Natural 2 Accident 6.0 1 YES 2 NO BY After 28e. PLACE OF INJURY — At home, ferm, street, fectory, office building, etc. (Specify) 69 3 Suicide 26f. LOCATION (Street end Number or Rural Route Number, City or Town, State) COMPLETED 6 Could not be after 28 1 DIRECTOR: 4 Homicide hours a Hem 29e. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my wiedge, danth occurred at the time, date end place, end due to the cause(e) and menner ee stated. TO THE HOSPITAL.
TO THE FUNERAL ID
TO FIED WITHIN 72 IN
TIMPORTANT: IF II restigation, in my opinion, death occured at the time, date end place, and due to the cause(e) and manner as stated, 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE

CAUSE OF DEATH (ITEM 27) (Type, Print)

12 REGISTRAR'S SIGNATURE

2003

0156



BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 687604

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within a not on the death. Page 6 may be retained by the hospital or attending physician.

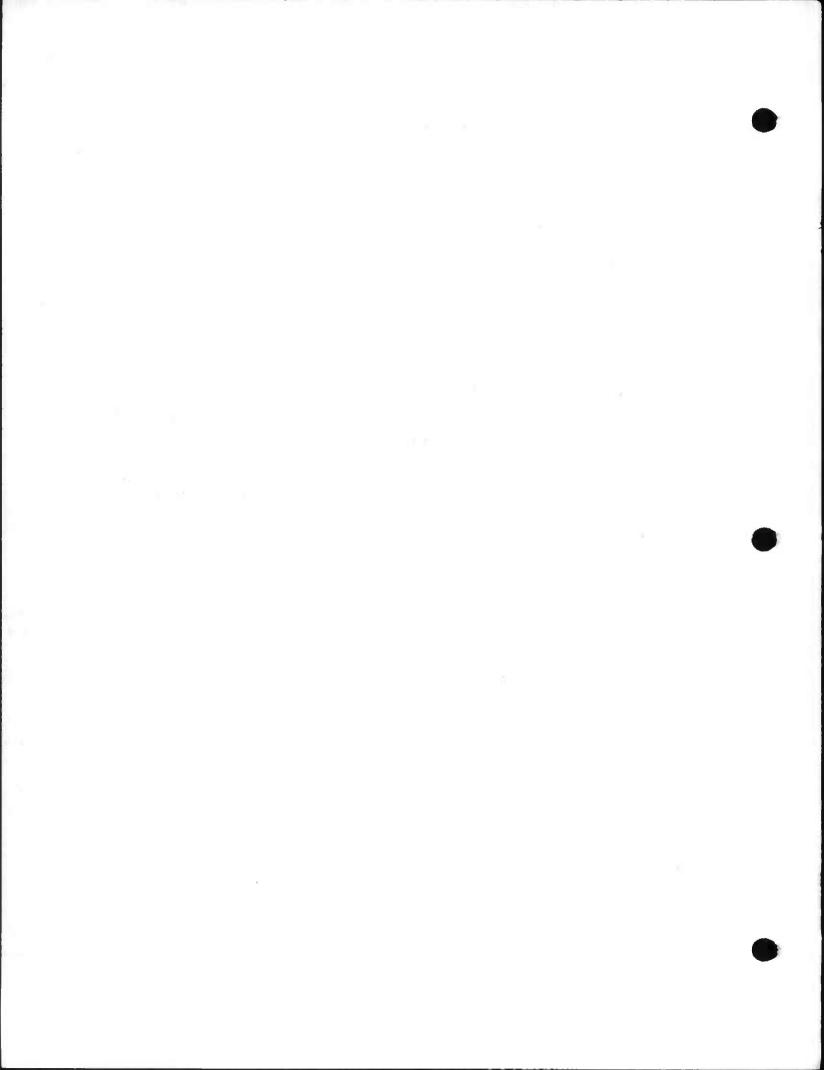
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any Inlury, or other traumatic event, the medical examiner must be notified at once.

		Amended item # 31	per P. Cra	igie Ca	rroll Co. 12/08	3/95	20	00000				
		FOR 1 STATE	STATE OF MARYL	AND / DEPAR	RTMENT OF HEALTH AND	MENTAL HYGIEN	E					
		REGISTRAR		CERTIF	ICATE OF DEATH	REG. NO						
	,	1. DECEDENT'S NAME (First, Middle, Last)	A + 1	C		2. DATE OF DEATH	AY Y	3. TIME OF DEATH				
	1	James Edward				Dec. 6,	1995	9:00 P M				
	١			(In yrs. last birthday)	IF UNDER 1 YEAR IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.	7. DATE OF BIRTH	8.	BIRTHPLACE (State or Foreign Country)				
		223 00 7001		60 YRS.		May 5, 19		Virginia				
m	1	9a. FACILITY NAME (If not institution, give street 4828 Osborne Road	it and number)		96. CITY, TOWN OR LOCATION OF E		9c. COUNTY	timore				
DIRECTOR		RESIDENCE OF DECEDENT			Reisterstow	///	Dal	rillore				
2		10a. STATE 10b. COUNTY		10c. CI1	Y, TOWN OR LOCATION			10d. INSIDE CITY				
片		Maryland Balti	imore		Reisterstowr	1		LIMITS?				
A P	1	10e. STREET AND NUMBER			10f. ZIP CODE		10g. CITIZEI	N OF WHAT COUNTRY?				
8		4828 Osborne Road			21136			USA				
FUNERAL	I		2. WAS DECEDENT EVER I FORCES? 1 X YES		13. WAS DECENDENT OF HISPA If yes, specify Cuban, Maxic		or No- 14	. RACE — American Indian, Black, White, etc.				
BY	ı	1 Never Married 2 Married 3 Wildowed 4 Divorced	IF YES, GIVE WAR OR D	DATES	1 YES 2 XNO Spec			Specify: White				
		15. DECEDENT'S EDUCAT	Korean W		USUAL OCCUPATION	16b, KIND OF BU						
1 !!		(Specify only highest grade con	mpleted)	(Give kind of life. Do NOT u	work done during most of working		hester					
교	1	6	College (1-4 or 5+)	Const	ruction			vements				
COMPLETED	l	17. FATHER'S NAME (First, Middle, Last)										
BEC		Emerson Joseph Atkins, Sr. Catherine Elizabeth Deavers										
10		19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)										
	ı	Nellie Ruth Atkins 4828 Osborne Road, Reisterstown, MD 21136										
181		20a. METHOD OF DISPOSITION 1X Buriel 2 Cremation 3 Remova 4 Donation 5 Other (Specify)			of disposition (Name of Memorial Park	1 4		r or Town, State 1e, MD				
21 SIGNATURE OF BINERAL SERVICE LICENSEE!												
Yell	Steven 1. Cline 934 S Main St, Hampstead, MD 21074											
3	1	23. PART i. Entar the diseases, or com	nolications that cause	d the death. Do								
		ahock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final Onset and Death										
8	1	disease or condition	Candiac	Arrest	_			15 minutes				
	Ì	resulting in death) a		A CONSEQUENCE O	F):			(2 WINO 102				
Z		C b	Cormany	Autery	Rueare							
		Sequentially list conditions, if any, leading to immediate	DUE TO (OR AS	A CONSEQUENCE D	P) ((
2	1	CAUSE (Disease or Injury	Atherosc	renotic	heart dula	Se						
	ı	that initiated events resulting in death) LAST	DUE TO (OR AS	A CONSEQUENCE O	F):							
CERTIFICATION	ı	d										
5 .	۱	PART ii. Other aignificant conditions of	ontributing to death b	out not resulting	in the underlying cause given in	Part i. 24a. WAS AN		24b. WERE AUTOPSY FINDINGS				
MEDICAL	ı	Congestive heart	failure			PERFOR		AMILABLE PRIOR TO COMPLETION OF CAUSE				
E E		4					05	OF DEATH? 1 □ YES 2 ☑ NO				
Z		DID TOBACCO USE CONTRIB	BUTE TO CAUSE C	OF DEATH Y	S NO UNCERTA	N 🗆						
PHYSICIAN:		25. WAS CASE REFERRED TO MEDICAL EXAMINER?	IOSPITAL:	26. PLACE OF DEA								
L S		1 YES 2 NO	☐ Inpetient 2 ☐ ER/Out;	patient 3 🗆 DOA	OTHER: 4 Nursing Home 5 Residence	8 C Other (Specify)						
F		27. MANNER OF DEATH 1 Netural 5 Pending	28a. DATE OF INJURY (Month, Day, Year)	28b. TIN	E OF 28c. INJURY AT WORK?	28d. DESCRIBE HOW I	NJURY OCCUR	ED				
B	ł	2 Accident Investigation	28a. PLACE OF INJURY		M 1 YES 2 NO							
9	i	3 Suicide 8 Could not be 4 Homicide determined	28f. LOCATION (Street a City or Town, State)	and Number or	Rural Route Number,							
		29a. CERTIFIER				<u> </u>						
COMPLETED	Ш	(Check only			ed at the time, date and pieca, and du							
2 MEDICAL EXAMINER: On the besis of exemination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause												
1 ш		296- SIGNATURE AND TITLE OF CERTIFIER			29c. LICENSE NU	MBER	29d. DATE S	GNED (Month, Day, Year)				
H		296- SIGNATURE AND TITLE OF CERTIFIER	eenter		N323	38	▶ 12.	7-95				
Е) ш		296- SIGNATURE AND TITLE OF CERTIFIER	eenter	EATH (ITEM 27) (Type	N323	38	DALTI	GNED (Month, Day, Year) 7-95 HORE, HD				

DEC 08 1995

Julia Davideor Reals



1 - STATE REGISTRAR	STATE OF M				OF HEALT		MENTAL HYGIE REG. NO			
1. DECEDENT'S NAME (First, Middle, Last)	Brigg	es-ke	kso	1				DAY, 30,	YEAR 3. TH	ME OF DEATH
4. SOCIAL SECURITY NUMBER		6. AGE (In yrs. les	st birthday)	IF UNDER 1	YEAR IF UNI	DER 24 HRS.	7. DATE OF BIRTH (Month, Day Year)		8 BIRTNPLACE	E (State or Foreign
577-70-5647 9a. FACILITY NAME (If not institution, give s	1 M 2 F	45	YRS.		OWN OR LOCA		Nov. 6,			gton,D.C
Prince Georges Ho		enter		90. 0111, 1	Cheve		CAIN	1,000	nce Geo	rge's
RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY	,	10c. CITY, TOWN OR LOCATION								
	e George':		10c. CIT		ttsvil	10				INSIDE CITY
100. STREET AND NUMBER	e George	5		пуан	101. ZIP CO			I 10g. CITI	ZEN OF WHAT	YES 2 NO
6607 Fairwood Roa	he					0784			ited St	
11. MARITAL STATUS	12. WAS DECEDENT	EVER IN U.S. AF	RMED	13. W			NIC ORIGIN? (Specify Y		14 BACE Ar	merican Indian
1 Never Married 2 Married 3 Widowed 4 Divorced	YES 2 X	NO		yes, specify Cu ☐ YES 2 🔯 N		an, Puerto Rican, atc.) ily:		Black, White Specify:	a, etc. Lack	
15. DECEDENT'S EDU (Specify only highest grade	CATION completed)			USUAL OCC	UPATION ring most of wo	rkina	16b. KIND OF B	USINESS/INC	DUSTRY	
Elementary/Secondary (0-12)	College (1-4 or 5+)	Hfa.	. Do NOT u	se retired.)	any mod or wo	nung.				
12		Ma	ainte	nance	, Post			vernm	ent	
17. FATHER'S NAME (First, Middle, Last)							AME (First, Middle, Maide	,		
Lawrence Brig	gs	10	b MAII IM	ADDRESS (_		ice L. Woo		0.41	
Sharon A. Johnso	n						Capitol He			20743
20a. METNOD OF DISPOSITION	11			OF DISPOSIT		IL,			City or Town, Si	
1 N Burial 2 Cremation 3 Rem 4 Donation 5 Other (Specify)	oval from State	cemetery, cri	amatory or o	ther place!		atom	12/5/95			
21. SIGNATURE OF FUNERAL SERVICE LIC	CENSEE	THICO	L11 11				ACIUTY ACIUTY BAL HOME	SULL	Land, M	D
Make TS	townst	TIT					Road, N.E.			
disease or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):										
PART II. Other eignificant condition	****				e given in	PERF	AN AUTOPSY ORMED?	AVAIL COMI OF D	E AUTOPSY FINDING ABLE PRIOR TO PLETION OF CAUSE EATH? YES 2 NO	
25. WAS CASE REFERRED TO MEDICAL				TN (Check on		10511111				
EXAMINER?	HOSPITAL:	ER/Oulpatient :	DOOA.	OTHER:		Residence	8 Other (Specify)			
27. MANNER OF DEATN 1 Natural 5 Pending	28e. DATE OF E (Month, De		28b. TIR		8c. INJURY AT WORK?		28d. DESCRIBE NOV	OC YRULAI	CURED	
2 Accident Investigation 3 Suicide 8 Could not be 4 Nomicide determined	28s. PLACE OF building, a	26a. PLACE OF INJURY — At homa, larm, building, alc. (Specify)					28I. LOCATION (Street and Number or Rural Route Number City or Town, State)			Number,
29a. CERTIFIER (Check only one) 1 CERTIFYING PNYS 2 MEDICAL EXAMINE							a to the cause(a) and me lime, data and placa,			manner ea stated.
294. BIGMATURE AND TITLE OF GERTIFIE	el m	un			29c. l	ICENSE NU	JMBER	29 TOAT	E SIGNED (Mont	h, Day, Year)
Opergunto / to	ugus 11	7			Do	117	30	Dec	enthos	1,1995
Auchs To P. Rock	COMPLETED CAUS	NO, 57	109 /	Ray be	um Ci	L. Co	. Son. M	120	748	
31. DATE FILED (Month, Day, Year) DEC 5 199	V	'S SIGNATURE	and a			1				

The state of the s

24 hours after death. Page 6 may be retained by the hospital or attending physician.	certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should in the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	the medical examiner must be notified at once.
THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the I he filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burlal, cremation, or removal.	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

31. DATE FILED (Month, Day, Year)
DEC 4 1995

32. REGISTRAR'S SIGNATURE

	FOR STATE REGISTRAR	STATE OF MARYLAND) / DEPARTI Certific			MENTAL HYGIEN REG. NO				
	1. DECEDENT'S NAME (First, Middle, Last)	А	-	7.112 01	<u> </u>	2. DATE OF DEATH	DAY YEAR	3. TIME OF DEATH		
	MILDRO		BROG	K5		NOV. 2	7. 1995	2:07 PM		
		SEX 6. AGE (in yrs.		ONTHS DAYS	HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year)	Cou	THPLACE (State or Foreign intry)		
	224-44-2269 11 9e. FACILITY NAME (If not institution, give street	M 2 K F 61	YRS.	A CITY TOWN	OR LOCATION OF DE		26,1934.	Orange Co.Va.		
œ	Washington Adventi				Park, Ma		Montgom			
5	RESIDENCE OF DECEDENT 10e. STATE									
DIRECTOR	Maryland Prince	Georges		Washin	gton,Mar	yland.207		10d. INSIDE CITY LIMITS? 1X YES 2 NO		
FUNERAL	6542 Buckland Court				20744		U.S.A.	F WHAT COUNTRY?		
BY FUN	11. MARITAL STATUS 12. 1 Never Married 2 Merried 3 Wildowed 4 Divorced	WAS DECEDENT EVER IN U.S. FORCES? 1 YES 27 IF YES, GIVE WAR OR DATES	ARMED NO	If yes, sp		NIC ORIGIN? (Specify Yein, Puerlo Rican, etc.)	Sp	ACE — American Indian, ack, White, atc. pocify: icanAmerican		
ED	15. DECEDENT'S EDUCATION (Specify only highest grade com		DECEDENT'S US	SUAL OCCUPATION AND AND AND AND AND AND AND AND AND AN	ON ost of working	16b. KIND OF BU	USINESS/INDUSTRY	· ·		
COMPLETED	Elementary/Secondary (0-12)	ollege (1-4 or 5+)	life. Do NOT use	retired.)	or worming	Departme	ent Of La	abor		
MP	12th Grade 17. FATHER'S NAME (First, Middle, Last)		cretary	У	18 MOTHED'S NA	ME (First, Middle, Maldel	o Sumama)			
BE CC	Unavailable				Edith		ii Gurierie)			
TO B	19a. INFORMANT'S NAME (Type/Print)	;	19b. MAILING A	DDRESS (Street	and Number or Rural I	Route Number, City or To	wn, State, Zip Code)	20777		
-	Jacqueline G. Brown					Ft.Washing				
	20s. METHOD OF DISPOSITION 1X Burlel 2 Cremation 3 Removal 4 Donation 5 Other (Specify)	from State	CEAND DATE OF	er place)			ocation - city or Brentwo	od, MD. 20722		
	21. SIGNATURE OF FUNERAL BERVICE LICENS		Lincoln	22. NAME A	ND ADDRESS OF FA	CILITYW.H.Bac				
	16 dwars	2W/R	mea					n,D.C.20010		
	23. PART I. Enter the diseases, or com shock, or heart failure. List			t enter the mo	ode of dying, suc	h aa cardiac or reap	piratory arrest,	Approximate Interval Between		
	IMMEDIATE CAUSE (Final									
				2 -		1.2	100			
	disease or condition reaulting in death)	CORDI	1AM	YA	ngen	Y DI	SEASS			
7	disease or condition	DUE TO (OR AS A CON	NSEQUENCE OF):	Y A	NTEN Y AN	Y DI	SEASS			
NOI	disease or condition resulting in death) a Sequentially list conditions,	DUE TO (OR AS A CONDUCTION OF A CONDUCTION OF A CONDUCTIO	NSEQUENCE OF:	T A 25107	nten H An	Y DI DARTE	Moser			
ICATION	disease or condition resulting in death) a	DUE TO (OR AS A COM	NSEQUENCE OF):		NTEN Y AN	Y DI	SRASS Moser			
TIFICATION	disease or condition reaulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING	DUE TO (OR AS A COM	NSEQUENCE OF):		N AN	Y DI	SRASS Mosera			
CERTIFICATION	disease or condition reaulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (OR AS A CON	NSEQUENCE OF):	,						
	disease or condition reaulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other algnificant conditions or	DUE TO (OR AS A CON	NSEQUENCE OF):	the underlyln	g cause given in	Part i. 24a, WAS A		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO		
	disease or condition reaulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (OR AS A CON	NSEQUENCE OF):	the underlyln	g cause given in ENE ANE UPHE NA	Part i. 24a. WAS A PERFC	IN AUTOPSY 2 PRMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?		
MEDICAL	disease or condition reaulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other algnificant conditions or	DUE TO (OR AS A CON-	INSECUENCE OF):	the underlyin	g cause given in ENE ANE UPHE NA	Part i. 24a. WAS A PERFC	IN AUTOPSY 2 PRMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE		
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MEDICAL	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other algnificant conditions or DID TOBACCO USE CONTRIB 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES TONO	DUE TO (OR AS A CONDITION OF TO CAUSE OF DEPITAL:	NSEQUENCE OF): INTERPOLATION OF THE PROPERTY	the underlying SSV SSV SSV SSV SSV SSV SSV SSV SSV SS	g cause given in PNE AND SCHLAND SCHLAND SCHLAND	Part i. 24a. WAS A PERFC	IN AUTOPSY 2 PRMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?		
PHYSICIAN: MEDICAL	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other algnificant conditions or DID TOBACCO USE CONTRIB 25. WAS CASE REFERRED TO MEDICAL EXAMINERY 1 YES THOU	DUE TO (OR AS A COM- DUE TO (OR AS A COM- ONTRIBUTING TO death but in UTE TO CAUSE OF D 28. F	NSEQUENCE OF:	the underlyin OF 28c. IN WW	g cause given in PARAME UNCERTAIL THE S Residence JURY AT ORK?	Part I. 24a, WAS A PERFC	N AUTOPSY PRIMED? 2 TO NO.	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO		
BY PHYSICIAN: MEDICAL	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other algnificant conditions or injury that initiated events resulting in death) LAST DID TOBACCO USE CONTRIB 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNIPA OF DEATH 1 Natural 5 Pending Investigation	DUE TO (OR AS A CONDUCTION OF TO CAUSE OF DUE TO CAUSE OF DUE TO CAUSE OF DUE TO CAUSE OF DUE TO CAUSE OF DUE TO CAUSE OF INJURY (Month, Day, Year)	NSEOUENCE OF): INSEOUENCE he underlyin SEV NO E Check only one OTHER: 4 Nursing Hor OF RY M 1	g cause given in PANA UNCERTAIL THE S Residence JURY AT ORK? YES 2 NO	Part i. 24a. WAS A PERFC 1 U YES AGO 1 Other (Specify) 28d. DESCRIBE HOW	IN AUTOPSY 2 PRIMED? 2 DRING 2 PRIMED? 2 DRING 2 PRIMED? 2 DRING 2 PRIMED? 2 PRIMED	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO			
BY PHYSICIAN: MEDICAL	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other algnificant conditions or DID TOBACCO USE CONTRIB 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNIP OF DEATH 1 Natural 5 Pending	DUE TO (OR AS A CONDUCTION OF DETAIL: Inpetiant 2 = ER/Outpetter 28e. DATE OF INJURY	NSEOUENCE OF): INSEOUENCE he underlyin SEV NO E Check only one OTHER: 4 Nursing Hor OF RY M 1	g cause given in PANA UNCERTAIL THE S Residence JURY AT ORK? YES 2 NO	Part I. 24a, WAS A PERFC 1 YES	IN AUTOPSY DRMED? 2 THO 2 THOUSE AND AUTOPSY DRMED? 2 THOUSE AND AUTOPSY DRMED? 3 THOUSE AND AUTOPSY DRMED PROPERTY DRMED PROP	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO			
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COMPLETED BY PHYSICIAN: MEDICAL	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other algnificant conditions of the court of the	DUE TO (OR AS A CONDUCTION OF TO CAUSE OF DUE TO CAUSE OF DUE TO CAUSE OF DUE TO CAUSE OF DUE TO CAUSE OF INJURY (Month, Day, Year) 28a. PLACE OF INJURY — A building, etc. (Specify)	NSEOUENCE OF): NSEOUENCE OF): NSEOUENCE OF): NSEOUENCE OF): N	the underlyin Check only one Check	g cause given in PLANS UPLE UNCERTAIL DESCRIPTION ONE SERVIC	Part i. 24a. WAS A PERFO 1 YES 1 Other (Specify) 28d. DESCRIBE HOW 28t. LOCATION (Street City or Town, State of the cause(a) and me time, date and place, in	IN AUTOPSY DRMED? 2 NAMED? 2 NAMED? INJURY OCCURED It and Number or Rur benner as stated.	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO		
BE COMPLETED BY PHYSICIAN: MEDICAL	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significant conditions or DID TOBACCO USE CONTRIB 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 VES NO 27. MANNER OF DEATH 1 Natural 5 Pending Investigation 3 Suicide 6 Could not be datermined 29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: O	DUE TO (OR AS A CONDUCTION OF CONTRIBUTION OF	NSEOUENCE OF): NSEOUENCE OF): NSEOUENCE OF): NSEOUENCE OF): N	the underlyin Check only one Check	g cause given in PAP ILA SCHLAND INCERTAIL INC	Part i. 24a. WAS A PERFO 1 YES 1 Other (Specify) 28d. DESCRIBE HOW 28t. LOCATION (Street City or Town, State of the cause(a) and me time, date and place, in	IN AUTOPSY DRMED? 2 NAMED? 2 NAMED? INJURY OCCURED It and Number or Rur benner as stated.	24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO		
E COMPLETED BY PHYSICIAN: MEDICAL	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other algnificant conditions or DID TOBACCO USE CONTRIB 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending Investigation 2 Accident Investigation 3 Suicide 6 Could not be datermined 29e. CERTIFIER (Check only One) 1 VERTIFYING PHYSICIAL EXAMINER: O	DUE TO (OR AS A CONDUCTION OF CONTRIBUTION OF	NSEOUENCE OF): NSEOUENCE OF): NSEOUENCE OF): NSEOUENCE OF): N	the underlyin Check only one Check	g cause given in PAP ILA SCHLAND INCERTAIL INC	Part i. 24a. WAS A PERFO 1 YES 1 Other (Specify) 28d. DESCRIBE HOW 28t. LOCATION (Street City or Town, State of the cause(a) and me time, date and place, in	IN AUTOPSY 2 DRIMED? 2 NO CURED It and Number or Rur tenner as stated. and due to the cause 29d. DATE SIGN	24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO		

Add was to the See See See

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the intending physician and completely filled in by the tuneral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiens prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

FOR STATE REGISTRAR 1 -

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. REG. NO

	114441												
	1. DECEDENT'S NAME (First, Middle, Last)								2. DATE (OF DEATH	W.	YEAR	3. TIME OF DEATH
	Fred	O. B	arnhard	lt					Nove	HBGR.		95	3:30 1
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs.	lest birthday)	IF UNDER 1		_	R 24 HRS.		OF BIRTH	1	8. BIRTN	PLACE (State or Foreign
	213 18 9488	S√S M 2 □ F	78	YRS.	MONTHS	DAYS	HOURS	MITTE.		14,19	917	Country	yland
	9s. FACILITY NAME (if not institution, give si		, , ,		9h CITY	TOWN	OR LOCAT	ION OF DE		17,1.		INTY OF DE	·
œ			1										
DIRECTOR	Washington Advent	ist Hosp	oital_		T	ako	ma P	ark			Mo	ntgom	ery
8	10e. STATE 10b. COUNTY	10c. CIT	Y, TOWN OF	LOCA	TION						10d. INSIDE CITY		
<u></u>	Maryland Princ	Bo	wie								LIMITS?		
	10a STREET AND NUMBER	1 20	101, ZIP CODE						10a. CIT	IZEN OF W	HAT COUNTRY?		
A	12319 Stonehaven	Tono				11.2	20715						States
FUNERAL	11. MARITAL STATUS	12. WAS DECEDER	T EVER WINE	10450	1 40 11					n en 14 M			
E	1 Never Married 247 Merried	FORCES?	XYES 2		If	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No— If yes, specify Cuben, Maxican, Puerto Ricen, etc.) 14. RACE — Black, W					— Americen Indien, , White, etc.		
BY	3 Widowed 4 Divorced	1941-	MAR OR DATES		1	YES	2 X NO	Specify	y.	NT -		Specif	White
	15, DECEDENT'S EDU			DECEDENT'S	HEHAL OC	CHRATI	ON		1 466	NO KIND OF BUS	DINEGE /IN	DISTRY	WILLEC
	(Specify only highest grade	completed)		(Give kind of life, Do NOT us	work done di			ing					politan
	Elementary/Secondary (0-12)	College (1-4 or 5		us Dri						ansit			-
COMPLETED	17. FATHER'S NAME (First, Middle, Last)		D	us DI.	rver					liddle. Melden			,
											Sumame)		
띪	Neal Barnhardt						1	iola		kman			
2	19e. INFORMANT'S NAME (Type/Print)									er, City or Tow			
7	Emma C. Barnhardt			12319		_		Lane	4	wie Ma			20715
	20s, METNOD OF DISPOSITION [XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	oval from State	20b. PLAC	CE AND DATE	OF DISPOSI	TION /N	lama of		OATE	20c. LO	CATION -	- City or To	wn, State
	4 □ Donellon 5 □ Other (Specify) Fort Lincoln Cemetery Dec. 2,1995 Brentwood Md.												
	21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEE								uneral	Uon	10 P	^
	► Kolvent b'	CITIM	Pal	20						d. Bow		-	
	23. PART i. Enter the diseesea, or	complications the	nt coused the	deeth. Do									Approximete
	shock, or heart failure.												interval Between Onset and Death
												Onset and Death	
	disease or condition resulting in death) a. CONG-ESTIVE HEALT F-AILURE DUE TO (OR AS A CONSEQUENCE OF):												
	DUE TO (OR AS A CONSEQUENCE OF): ORONARAY ARTCRY DisCASE Sequentially list conditions												
CERTIFICATION	Sequentially list conditions, Oue TO (OR AS A CONSEQUENCE OF):												
ATI	OUE TO (OR AS A CONSEQUENCE OF):												
5	LAUSE (Disease Dr Injury hat initiated events secuting in death) LAST d. CHRONIC OBSTRUCTIVE FULMONARY DISCASE. C. AND CORONARY ISCHEMIA. C. CHRONIC OBSTRUCTIVE FULMONARY DISCASE.									1			
Ē	resulting in death) LAST	CHRI	DAlle C	oker	RUC	77]/	0 +		10.10	214	1,6	KAR	
SE										12/	-,0	C//2 C	
	PART II. Other algnificent condition									24s. WAS AN	AUTOPSY	24b.	WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
MEDICAL	SQUAMOUS C	ELL	CA.	OF	RIG	HI	- 4	UN	16	1 TYES 2	1		COMPLETION OF CAUSE DF DEATH?
					-						as my		1 YES 2 NO
	DID TOBACCO USE CONT	RIBUTE TO CA	AUSE OF D	EATH Y	FS 🖂 N	10 L] UN	CERTAI	NM				
AN	25. WAS CASE REFERRED TO MEDICAL			LACE OF DEA									
S	EXAMINER? 1 YES 2 NO	HOSPITAL:	□ E9/Outcetled	2 DOA	OTHER		-	Danidanaa	e 🗆 Other	(Parelly)			
PHYSICIAN:	27. MANNER OF OEATN	28a. OATE O		28b. Till	_	_	JURY AT	Hesidence	6 Other	CRIBE NOW I	INJURY O	CCURED	
	1 Partural 5 Pending	(Month,	Day, Year)		JURY	W	ORK? YES 2	□ MO				0007120	
ВУ	2 Accident Investigation	260 DI ACE	OF INJURY A	home form	eterat fast				261 1 00	ATION (Street	and Numb	as as Duml f	South Number
0	3 Suicide 6 Could not be 4 Homicide detarmined		, etc. (Specify)	t frome, rettil,	Street, lact	ory, orn	CO			or Town, State		er or nurer r	water rumosi,
COMPLETED													
PL	29a. CERTIFIER (Check only	ICIAN: To the best of	of my knowledge	, death occur	red at the ti	me, dat	te end plac	ce, end due	e to the cau	ise(e) end me	nner as st	ated.	
OM	one) 2 MEGICAL EXAMINI	B: On the beals of	examination end	or investigati	on, In my o	pinion,	desth occ	ured at the	time, date	and place, er	nd due to	the ceuse(s) end menner se stated.
EC	290. SIGNATURE AND TITLE OF COUTFIE	H)					29c. LI	CENSE NU	MBER	-	29d. D/	TE SIGNED	(Month, Day, Year)
m	X40101. 6	MIO						185.	51	MO.	1	NO	V.28 95
5	30. NAME AND ADDRESS OF PERSON WI	O COMPLETED CA	USE OF DEATH (ITEM 27) (Typ	e, Print)		1	.,	T.A.		10	12	111
	30 NAME AND ADDRESS OF PERSON WES AMIL NEIM	47 ND.	7610	0 01	HLC	14	. / [<i>v</i> .	ITHK	DHA	1//	24	2
	31. DATE FILED (Month, Day, Year)	3. REGISTA	AR'S SIGNATI	E 0 40								011	Seen.
	DEC 4 1995	gala di	waterda	400									

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	FOR 1 - STATE REGISTRAR	STATE OF MARYLAND / DEPARTM	MENT OF HEALTH AND	MENTAL HYGIENE REG. NO.							
- 3	1. DECEDENT'S NAME (First, Middle, Last)			2. DATE OF DEATH	3. TIME OF DEATH						
	RONALD A. BUF	RNER Jr.		NOV. 26,	1995 8:04 A M						
			F UNDER 1 YEAR IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)	BIRTHPLACE (State or Foreign Country)						
		19 YRS.		May 28, 1976	Maryland						
· c	9a. FACILITY NAME (If not institution, give atreet		b. CITY, TOWN OR LOCATION OF E		OUNTY OF DEATH						
DIRECTOR	PRINCE GEORGES F	HOSPITAL CENTER	CHEVERLY	P.	RINCE GEORGES						
HE (10e, STATE 10b, COUNTY	10c. CITY, 1	OWN OR LOCATION		10d. INSIDE CITY LIMITS?						
		EV NEW CONTROL BOOK									
RAL			10f. ZIP CODE	10g. Ct	ITIZEN OF WHAT COUNTRY?						
FUNERAL	4002 Wharton Turn	. WAS DECEDENT EVER IN U.S. ARMEO	20715	Un:	ited States						
	1 🔀 Never Married 2 🗌 Married	FORCES? 1 YES 2 NO	If yes, specify Cuban, Maxic	an, Puarto Rican, stc.)	Black, White, etc. Specify:						
BY	3 Widowed 4 Divorced	IL TES, GIVE WAN ON DATES	1 YES 2 NO Spec	ny	White						
COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade com-	(Give kind of wor	k done during most of working	16b. KIND OF BUSINESS/II	NDUSTRY						
Ë	The state of the s	ollege (1-4 or 5+)									
N N	12 17. FATHER'S NAME (First, Middle, Last)	Student		School AME (First, Middle, Maiden Surname)							
EC	Ronald Anthony Bur	mor Cr									
00	ton. INFORMANT'S NAME (Type/Print)			Linda Dawn Hill I Route Number, City or Town, State, 2							
2	Ronald A. Burner.	Sr. 4002 W	narton Turn Boy	wie Maryland 20	0715						
	20a METHOD OF DISPOSITION TO Burlet 2 Cremation 3 Removal	20b. PLACE AND DATE OF	DISPOSITION (Name of	DATE 20c. LOCATION	- City or Town, State						
	4 Donation S Other (Specify)	Lakemont M		s 11/30/95 Dav	idsonville Md.						
	21. SIGNATURE OF FUNERAL SERVICE LICENS	E D	22. NAME AND ADDRESS OF F Robert E. EV	ans Funeral Ho	me, P.A.						
	ROUNI C.	Corns Mes		lis Rd. Bowie							
	23. PART I. Enter the diseases, or com ehock, or heart fellure. Liet	plications that caused the deeth. Do not only one cause on each line.	enter the mode of dying, au	ch as cardiac or respiratory s	arrest, Approximeta Interval Between						
	IMMEDIATE CAUSE (Finel disease or condition	MILL TIPLE IN THE			Onset and Death						
	resulting in death) a	DUE TO (OR AS A CONSEQUENCE OF):									
101	Sequentially list conditiona, If any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF):										
3	CAUSE (Disease or Injury										
F	that initiated evente resulting in death) LAST	DUE TO (OR AS A CONSEQUENCE OF):									
CERTIFICATION	d				1						
	PART II. Other algnificent conditions conditions	ontributing to death but not resulting in	the underlying cause given i	n Part I. 24s. WAS AN AUTOPS PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO						
MEDIC				1 NVYES 2 - NO	COMPLETION OF CAUSE OF DEATH?						
ME				/	1 YES 2 NO						
AN.		UTE TO CAUSE OF DEATH YES		IN 🗆							
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER? W XYES 2 NO		OTHER:								
HYS	27. MANNER OF DEATH	26a. OATE OF INJURY 26b. TIME (□ Nursing Home 5 □ Rasidence DF 28c: INJURY AT	26d. OE\$CRIBE HOW INJURY C	OCCURED						
	1 Natural 5 Pending 2 Accident Investigation	(Menth, Day, Noar) 11 26 95 0125	IY, WORK?	OCCUPANT OF	AUGO VE FIXED						
	3 Suicide 6 Could not be	26s. PLACE OF INJURY — At home, farm, stra- building, stc. (Specify)	set, factory, offica	28f. LOCATION (Street and Numb City or Town, State)	ber or Rural Route Number, M						
ETE	4 Homicide determined	STREET			BRIDGERP, BOWLE						
COMPLETED		N: To the best of manufeledge, death occurred	st the time, data and place, and de	us to the cause(a) and manner as a	itated.						
D BE COM	One) 2 X MEDICAL EXAMINER: C	On the basis of examination and/or investigation,	In my opinion, death occured at the	ne time, data and placa, and dua to	the cause(a) and manner as steled.						
BE C	296 SIGNATURE AND TITLE OF CERTIFIER	MOAI	29c. LICENSE N		ATE SIGNED (Month, Day, Year)						
TO B	June 47	your IIW	0.C.M	· E	NOV. 27,1995						
	MARIO F. GOLVE	The Mark of Delith (FEM 27) (Type, P.		timore, Mary	land 21201						
	31. DATE FILEO (Month) Day, 1995	Jahn Dandsorhadel									

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNETAL ORECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burlat-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burlat, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

FOR STATE REGISTRAR 1 -

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

	1. DECEDENT'S NAME (First,							2. DATE OF DEATH 3. TIME OF DEAT					
	Kathryn	ary Ba		MONTH DAY YEAR						12:18 A W			
	4. SOCIAL SECURITY NUMB	birthday)	IF UNDER	t YEAR	IF UNDER	24 HRS.	7. DATE OF BIRTH	S. BIRTH	IPLACE (State or Foreign				
	186-16-	0582	1 M 2 F	73	YRS.	MONTHS	DAYS	HOURS	MIN.	(Month, Day, Year)	1022	y)	
1	9a. FACILITY NAME (If not in		9h CITY	April 7, 1922 P									
œ	Holy Cross												
2	RESIDENCE OF DEC		Lai			Silver Spring Montgon							omery
DIRECTOR	10a. STATE	10b. COUNTY	Y		10c. CIT	Y, TOWN	OR LOCAT	TION					10d, INSIDE CITY
8	Maryland	Monts	gomery		R	ockv:	i 11 a						LIMITS?
	10e. STREET AND NUMBER		5				-	. ZIP COD	E		10g. CIT	ZEN OF Y	VHAT COUNTRY?
FUNERAL	4705 Falcon	Stree	et					201	853			USA	
N	11. MARITAL STATUS	Dere		VT EVER IN U.S. AR	MED	13.	WAS DEC			IIC ORIGIN? (Specify Yes	or No.		E — American Indian.
	1 Never Married 2 🔯	Married	FORCES?	MAR OR DATES			If yes, sp	ecify Cubi	in, Maxica	n, Puerto Rican, etc.)		Spec	E — American Indian, k, Whita, atc.
ВҰ	3 Widowed 4 Divo	road	17 TES, GIVE	MAN ON DATES			1 1 123	ZA NO	Specia	<i>y</i> .		Spec	White
0		EDENT'S EDU		16a. DE	CEDENT'S	USUAL O	CCUPATIO	DN		16b. KIND OF BU	SINESS/INE	DUSTRY	
E	(Specify only Elementary/Secondary (0	y highest grade	College (1-4 or 5	life	Do NOT u	work done se retired.)	during mo	ist of worki	ng				
집	12				omema	aker				Own Ho	me		
COMPLETED	17. FATHER'S NAME (First, M	iddle, Last)						18. MOT	HER'S NA	ME (First, Middle, Maiden	Surname)		
	Edmund	McCar	rty					1	Mary	Ferrick			
BE	19s. INFORMANT'S NAME (7	ype/Print)	-	198	. MAILING	ADDRES	S (Street a		_	Route Number, City or Tow	rn, State, Zip	Code)	
2	Robert A.	Baile	V		470)5 F	100	n Sti	root	Rockvill.	о МТ	20	1853
	20a. METHOD OF DISPOSIT	ION		20b. PLACE A	NDDATE	OF DISPO	SITION /N/	ame of		DATE 20c. LO	CATION -	City or To	wn. State
	1 Surfal 2 Cremation 4 Donation 5 Other		oval from State	Gate	of H	ther place	n Ce	mete	rv 1	2/07/95 5	ilvo	r Sn	ring MD
	21. SIGNATURE OF FUNERA		CENSEE	1000	02 11	22.	en Cemetery 12/07/95 Silver Spring, MD						
		-		0		I	rand	cis 3	J. Co	ollins Fun	eral	Home	. Inc.
	Open	so C	2 West	Herr		E .	00 t	Jnive	ersit	y Blvd.W.	Sil.	Spr.	MD 20901
	iMMEDIATE CAUSE (Fir disease or condition_	sart fallure.	complications the			not ente	r ths mo	de of dy	ing, suc	h as cardiac or resp	iretory sn	rest,	Approximats Interval Between Onset and Desth
	resulting in dawth)	Sequentisliy list conditions, farm, leading to immediate suss. Enter UNDERLYING C. Sequentially list conditions, farm, leading to immediate suss. Enter UNDERLYING C. Sequentially list conditions, farm, leading to immediate suss. Enter UNDERLYING C. Sequentially list conditions, farm, leading to immediate suss. Enter UNDERLYING C. Sequentially list conditions, farm, leading to immediate suss. Enter UNDERLYING C. Sequentially list conditions, farm, leading to immediate suss. Enter UNDERLYING C. Sequentially list conditions, farm, leading to immediate suss. Enter UNDERLYING C. Sequentially list conditions, farm, leading to immediate suss. Enter UNDERLYING C. Sequentially list conditions, farm, leading to immediate suss. Enter UNDERLYING C. Sequentially list conditions, farm, leading to immediate suss. Enter UNDERLYING C. Sequentially list conditions, farm, leading to immediate suss. Enter UNDERLYING C. Sequentially list conditions, leading to immediate suss. Enter UNDERLYING C. Sequentially list conditions, leading to immediate susp. Enter UNDERLYING C. Sequentially list conditions are supplied to immediate susp. Enter UNDERLYING C. Sequentially list conditions are supplied to immediate susp. Enter UNDERLYING C. Sequentially list conditions are supplied to immediate susp. Enter UNDERLYING C. Sequentially list conditions are supplied to immediate susp. Enter UNDERLYING C. Sequentially list conditions are supplied to immediate susp. Enter UNDERLYING C. Sequentially list conditions are supplied to immediate supplied to immed											
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CERTIFICATION	Sequentially list condit if any, leading to imme		bue to	IDA AS A CONSEC	DUENCE O	P):	-	7					
S	cause, Enter UNDERLY		a Co	ronare			Tier	00	26	roza			years
E	that initisted events resulting in death) LAS		DUE TO	OR AS A CONSEC	HENCE O	P)			17.			,	,
H	resulting in death) LAS		d										
	PART II. Other significa	nt condition	na contributing to	death but not r	eaulting	In the u	nderlyin	O CRUSA	alven in	Part I. 24a, WAS AN	ALITOPSY	241	. WERE AUTOPSY FINDINGS
EDICAL					ouu. i.i.g			9	9	PERFO	RMED?		AVAILABLE PRIOR TO COMPLETION OF CAUSE
ă										1 TYES :	NO		OF DEATH?
Σ													1 YES 2 NO
ä	DID TOBACCO U		RIBUTE TO CA						CERTAI	N LET			
C	25. WAS CASE REFERRED T EXAMINER?	O MEDICAL	HOSPITAL:	26. PLAC	E OF DEA	OTHE							
YSI	1 YES 2 NO		1 🗆 Inpatient 2	ER/Outpatient 3	□ DOA			ne 5 🗆 R	lesidence	6 C Other (Specify)			
BY PHYSICIAN:		Pending Investigation	28a. DATE O (Month,	F INJURY Day, Year)	28b. TIR	ME OF JURY M	Wo	JURY AT ORK? YES 2	□ NO	28d. DESCRIBE HOW	INJURY OC	CURED	
	3 Suicide 8	Could not be determined	28e. PLACE building	OF INJURY — At ho , atc. (Specify)	me, ferm,	street, fac	ctory, offic	a.		281. LOCATION (Street City or Town, State	and Numbe)	or Rural	Route Number,
COMPLETED	Condon only									to the cause(s) and ma time, data and place, a			a) and manner ea stated,
BE C	29b. SIGNATURE AND TITLE	OF CERPIFIE	Refer 6	2000		la	al	29c. LIC	ENSE NU	MBER 7 6 7 0	29d, DAT	E SIGNE	(Month, Day, Year)
5	30. NAME AND ADDRESS O	F PERSON WI	O COMPLETEO CAI	SE OF OEATH (ITE	_	e, Print)	-1	1	1	0	0	-/	7/93
	KICHARD 31. DATE FILED (Month, Day,	Year)	DE LAN	E HD	981	1 6	COR	614	the	SILVER	SPR	149,	HD 28902
	DEC 0	7 1995	Jabia	AR'S SIGNATURE	u								

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retain	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 sho	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burlal, cremation, or removal.
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	1 - FOR STATE REGISTRAR	STATE OF MARYL		RTMENT OF I		MENTAL HYGIEN				
	1. DECEDENT'S NAME (First, Middle, Lest)	BARBASH	,			1	3, 1995	3. TIME OF DEATH 3. 45 DM		
	4. SOCIAL SECURITY NUMBER 129–10–3118		(In yrs. lest birthday) 82 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) 02/24	8. B	HRTHPLACE (State or Foreign Country) USSIA		
OR	90. FACILITY NAME (If not institution, give Sinai Hospital	street end number)			or location of di imore	EATH	9c. COUNTY O			
DIRECTOR	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNT	TY		10d. INSIDE CITY						
	MD Balti	imore	Ва	ltimore	or, ZIP CODE		1 YES 2 NO			
ERA	2500 West Belvede	ere Avenue			21215		USA	OF WHAT COUNTRY?		
BY FUNERAL	11. MARITAL STATUS 1 Never Merried 2 Merried 3 Widowed 4 Divorced	12. WAS DECEDENT EVER II FORCES? 1 YES IF YES, GIVE WAR OR D	2 K NO	13. WAS DE It yes, s ₁ 1 YEs	RACE — American Indian, Black, White, etc. Specify: White					
9	15. DECEDENT'S EDI (Specify only highest grad	UCATION de completed)	16a. DECEDENT'S	USUAL OCCUPATI	ON ost of working	16b. KIND OF BU	ISINESS/INDUST	RY		
COMPLETED	Elementery/Secondary (0-12)	College (1-4 or 5+)	life. Do NOT u	nce CLU		Privat	e Indus	strv		
OMI	17. FATHER'S NAME (First, Middle, Last)		THOUSE	ince obe	18. MOTHER'S NA	AME (First, Middle, Meider				
BEC	Samuel Barbash				Julia 1	Pasternak				
TO E	190. INFORMANT'S NAME (Type/Print) Kathie Cole				end Number or Rural Bouleval	Route Number, City or Tox	vn, Stete, Zip Cod da MD 2	,		
	20e. METHOD OF DISPOSITION	201	. PLACE AND DATE				OCATION — City			
	1 XBuriel 2 Cremetion 3 Ref 4 Donetion 5 Other	Tin	netery, crematory or dean. Men	orial G			ney MD			
200	21. SIGNATURE OF FUNERAL BERVICE L	JCENSEE			d Sagel 1 Rockville	Funeral Di e Pike Ro		n e MD 20852		
	23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, abock, or haert failure. List only one ceuse on each line. IMMEDIATE CAUSE (Finel disease or condition resulting in deeth) a. Ventricular Fibrillation Arrest									
2		Chronic	Ventri c	war to				months		
ATIO	Sequentielly list conditions, if any, leading to immediate cause. Enter UNDERLYING	DUE TO (OR AS A	A CONSEQUENCE O	OF):				kore		
CERTIFICATION	CAUSE (Disesse or injury that initiated eventa resulting in deeth) LAST	Cardion	allure	7:				740		
	PART II. Other significent condition			In the underlyle	on cause observir	Part I. 24e, WAS A	AUTOBEV	24b, WERE AUTOPSY FINDINGS		
IN: MEDICAL	Polymicrobial mellitus, paysi did tobacco use con	Sepsis, inivitis	Moninsuli) Of Death Y	n depen	dent du	ubelo 1 PERFO	RMED?	AMILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH? 1 YES 2 NO		
ICIA	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:		OTHER:						
PHYSICIAN:	1 YES 2 Y NO 27. MANNER OF DEATH	1 Inpatient 2 ER/Out	28b, Til	AE OF 28c. IN	JURY AT	8 Other (Specify) 28d. DESCRIBE HOW	INJURY OCCUR	ED .		
ВУ Р	1 Netural 5 Pending Investigation	(Month, Day, Year)	IN		YES 2 NO					
E :	3 Suicide 8 Could not be 4 Homicide determined	28e. PLACE OF INJURY building, etc. (Spe	Y — At home, ferm,	street, factory, offi	се	281. LOCATION (Street City or Town, State		lural Route Number,		
COMPLET	onel only	SICIAN: To the best of my know						ruse(e) and manner on stated.		
	296. MATURE AND TITLE OF CERTIFI	ER			29c. LICENSE NU	IMBER	29d, DATE SK	GNED (Month, Day, Year)		
TO BE	Miles				A 5240	2321 HP 99	p Dace	mber 3, 1995		
-	30. NAME AND ADDRESS OF PERSON W	WHO COMPLETED CAUSE OF DE	EATH (ITEM 27) (Typ	e, Print) Sp i TAL	RAIT	MORE, M	*			
	31. DATE FILED (Month, Day, Year)	32. BEGISTRAR'S SIGN	NATURE OF ROLL	Joint.		MURE, M	<u> </u>			

the state of the rais govern 2 1 3 4 4 5 n v E. Joseph Pull Hundhami. 13/4 HHV a Aren A Some Season to the state of the season of th Was part on the first and the and their following to the company of the company o

DIVISION OF VITAL RECORDS, P.O. BOX 68760

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	STATE OF MARYI				MENTAL HYGIEN	E	
1. DECEDENT'S NAME (First, Middle, Last)	m BONI	1	JR.	DEATH	REG. NO 2. DATE OF DEATH MONTH NO V 2	5 1995"	3. TIME OF DEATH
4. SOCIAL SECURITY NUMBER 5		(In yrs. last birthday)	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) Sept. 25,1	8.	BIRTHPLACE (State or Foreign Country) ashington, DC
Se. FACILITY NAME (If not institution, give stree				OR LOCATION OF D		9c. COUNTY	
Holy Cross Hospital				Spring		HOII	
Maryland Mont	gomery	10c. CITY,	Potoma				10d. INSIDE CITY LIMITS? 1 YES 2 X NO
100. STREET AND NUMBER 12408 Copenhaver T	errace		10	I. ZIP CODE 2085	4		d States
11. MARITAL STATUS 1 Never Married 2 XXMerried 3 Widowed 4 Divorced	2. WAS DECEDENT EVER FORCES? 1 YES IF YES, OIVE WAR OR I	2 2 NO	If yes, sp		NIC ORIGIN? (Specify Yean, Puerto Rican, etc.)	or No- 14.	RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCAT (Specify only highest grade cor Elementary/Secondary (0-12)		16e. DECEDENT'S U (Give kind of wo	ork done during mo retired.)	ON ost of working	166. KIND OF BU	siness/indus	
17. FATHER'S NAME (First, Middle, Leat) James William	Bonbrest,			Virg	AME (First, Middle, Malder inia Heath		
190. INFORMANT'S NAME (Type/Print) Rosemarie H. Bonbr	rest				Route Number, City or Tow		myland 20854
23. PART I. Enter the diseases, or cor shock, or heert fellure. List IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions,	ot only one cause on PA	M00348 ed the death. Do no asch line. V C V M A CONSEQUENCE OF	ROCKV of enter the mo	ode of dying, au	ryland 20	850-28	
It any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events		A CONSEQUENCE OF					
resulting in death) LAST							
		but not resulting in		g ceuse given ir	Part I. 24a. WAS AI PERFO	RMED?	AMILABLE PRIOR TO
PART II. Other significant conditions STOPHU DID TOBACCO USE CONTRI 25. WAS CASE REFERRED TO MEDICAL EXAMINER?	BUTE TO CAUSE (OF DEATH YES	S NO E	UNCERTA	PERFO	RMED?	AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
PART II. Other significant conditions STOPUL DID TOBACCO USE CONTRI 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Notural 5 Pending Investigation	BUTE TO CAUSE (HOSPITAL: Inpetient 2 ER/Ou 280. DATE OF INJURY (Month, Day, Yeer) 280. PLACE OF INJURY	OF DEATH YES 26. PLACE OF DEATH (planting 3 DOA (Seb. TIME INJU RY — At home, farm, si	NO EN (Check only one) OTHER: 4 Nuraing Hor HY M 1	DINCERTAL DINCERTAL	PERFO 1 YES 6 Other (Specify) 28d. DESCRIBE HOW	RMED? 2 (XNO INJURY OCCUR and Number or	AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2X NO
PART II. Other significant conditions STOPUL DID TOBACCO USE CONTRII 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending Investigation 3 Suicide 8 Could not be determined 29e. CERTIFIER (Check only 1 NO CERTIFYING PHYSICIAL CONTRIBUTION)	BUTE TO CAUSE (HOSPITAL: A Inpatient 2 = ER/Ou 280. DATE OF INJURY (Month, Day, Year) 260. PLACE OF INJUR building, etc. (Sp	OF DEATH YES 26. PLACE OF DEATH ripatient 3 DOA 26b. TiME INJ. RY — At home, farm, si	O PU M (Check only one) OTHER: 4 Nursing Hor WY M 1 Ireet, factory, office d at the time, det	UNCERTA	PERFO 1 YES 6 Other (Specify) 28d. DESCRIBE HOW 28f. LOCATION (Street City or Town, State	INJURY OCCUP and Number or	COMPLETION OF CAUSE OF DEATH? 1 YES 2X NO RED Rural Route Number,

YEAR 1995

3. TIME OF DEATH

10d. INSIDE CITY 1 YES 2 X NO

White

Approximate Interval Between Onset and Death

24b. WERE AUTOPSY FINDINGS

AVAILABLE PRIOR TO

1 YES 2 NO

12/1/95

COMPLETION OF CAUSE

DAYS

8. BIRTNPLACE (State or Foreign Country)

Mississippi

Montgomery

United States

Specify:

14. RACE — American Indian, Black, Whita, etc.

12:30 pm

permit. Pages 1, 2, 3 should

nsit

DIRECTOR

FUNERAL

BY

COMPLETED

BE

2

CERTIFICATION

MEDICAL

PHYSICIAN:

ВУ

4 Homicide

COMPLETED

BE

9

tending prysicial	as the burial-tra		
arter death. Page 6 may be retained by the hospital or after	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the but		ed at once.
age o may be retain	director, page 5 sho		MPORTANT: if item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
arier death. P	y the funeral	noval.	cal examin
il 24 nours a	ly filled in by	ation, or rem	the medic
executed with	and complete	o burial, crem	natic event.
ceruncate be	ding physician	ygiene prior t	other traur
nat the death	by the attent	and Mental H	ny injury, or
w requires tr	been signed	pt. of Health	3 shows ar
ICIAN: The IS	certificate has	the State De	, or item 2
NOING PHYS	R: After this of	er death with	Is marked
IAL OR ALLE	VAL DIRECTO	72 hours after	If Item 28
TO THE HOSPITAL OF ALTENDING PHYSICIAN: The Jaw requires man the death certificate be executed with	THE FUNE	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to	MPORTANT:

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH Margaret P. Bell December 4. SOCIAL SECURITY NUMBER 7. DATE OF BIRTH 8. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. September 1 🗌 M 2 💢 F VDS 240-50-7376 Sa. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH Holy Cross Hospital Silver Spring 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION Maryland Chevy Chase Montgomery 10e. STREET AND NUMBER 10g. CITIZEN OF WHAT COUNTRY? 101 ZIP CODE 3206 Rolling Road 20815 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☑ NO IF YES, GIVE WAR OR DATES 11 MARITAL STATUS 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No—if yes, specify Cuban, Mexican, Puerlo Rican, etc.) 1 Never Married 2 Married 1 YES 2 NO Specify: 3 Widowed 4 Divorced 18a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16b. KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5 +) 4 Teacher Education 17. FATNER'S NAME (First, Middle, Lest) 18. MOTNER'S NAME (First, Middle, Maiden Surname) James Edgar Poague Mildred Lobdell 19a. INFORMANT'S NAME (Type/Print) 19b. MAILIND ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) William D. Bell 3206 Rolling Road Chevy Chase, Maryland 20815 20b. PLACE AND DATE OF DISPOSITION (Name of commetery, crematory or other place) December 2, 129 Montgomery Crematorium Inc. 20a. METNOD OF DISPOSITION
1 □ Burial 2 X Cremation 3 □ Ramoval Irom State 20c. LOCATION - City or Town, State 1995 Bethesda, Maryland 4 Donation 5 Other (Specify) . 22 NAME AND ADDRESS OF FACILITY Robert A. Pumphrey Funeral Home/ Bethesda- Chevy Chase, Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814-3501 21. SIGNATURE OF FUNERAL SERVICE LICENSEE M00335 23. PART I. Enter the discusses, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) a. GASTROIWTESTIWAL BCEFOING

DUE TO (OR AS A CONSEQUENCE OF): BREAST DUE TO (OR AS A CONSEDUENCE OF) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF) that initiated eventa reaulting in death) LAST PART II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 1 | YES 2 | NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES 🗌 NO 🏿 UNCERTAIN 🗍 26. PLACE OF DEATN (Check only one) 25. WAS CASE REFERRED TO MEDICAL HOSPITAL: OTHER: 1 YES 2 NO Inpetient 2 - ER/Outpetient 3 - DOA 4 Nursing Nome 5 Residence 8 Other (Specify) 27. MANNER OF DEATN 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE NOW INJURY OCCUREO 1 Natural 5 Pending Investigation 1 YES 2 NO 2 Accident 28a. PLACE OF INJURY — At home, farm, street, factory, offica building, alc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Sulcide 8 Could not be

29a. CERTIFIER
(Check only one)

2 MEDICAL FXAMINES: On the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as attend. 2 MEDICAL EXAMINER: On this basis of examination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(s) and manner as stated.

MA

29d. DATE SIDNED (Month, Day, Year) 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER Sool

D18219

Sept b. 30. NAME AND ADDRESS OF PERSON WNO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

STEPHEN STAKE CHWOOVER OUD 8300 CORPORME DR

31. DATE FILED (Month, Day, Year)

32, REGISTRAR'S SIGNATURE Julia Davidson Randa & DEC 04 1995

DHMH-18 Rev 1/89

DHMH-18 Rev 1/89

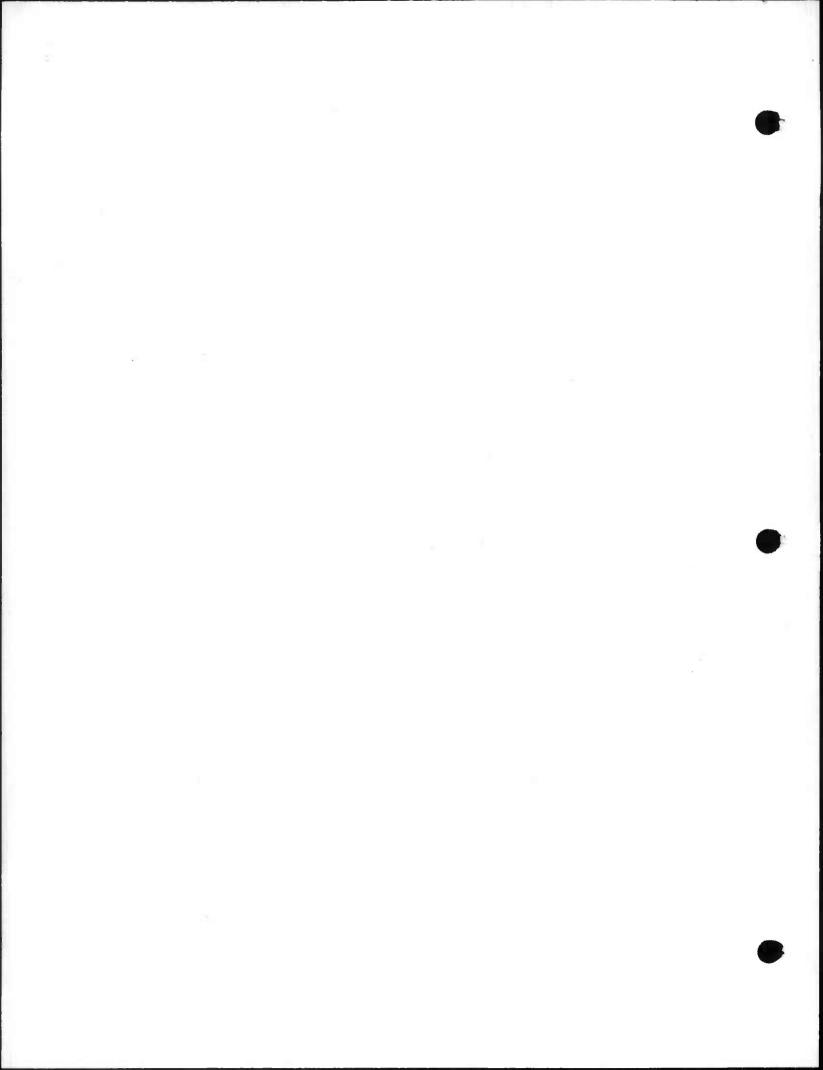
1 - FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

09289
80
P.O.
RECORDS,
OF VITAL
DIVISION

		1. DECEDENT'S NAME (First, I ROBERT	Middle, Last)	D	DOI	пра					2. DATE	OF DEATH	AY	YEAR	3. TIME OF DEA	ан
		Dec. 1 1995) А.м			
		577 50 2158		1 XM 2 F		58 YRS.	MONTHS	DAYS	HOURS	MIN.	(Mon	OF BIRTH	27 1	Country)		
pinou		9a. FACILITY NAME (If not inst					9b. CIT	Y, TOWN	OR LOCATI	ION OF DI		10,19		WASNI	Ington,	D. C
U.Z.O. physician. burial-transit permit. Pages 1, 2, 3 should	DIRECTOR															
Jes 1,	EC	10a. STATE	10c. C	ITY, TOWN	OR LOCA	TION						10d, INSIDE CIT	Y			
€.		Maryland		Silve	er Sp	oring	3					LIMITS?] NO			
E ber	FUNERAL	10s. STREET AND NUMBER		101, ZIP CODE 10g. CITIZEN OF WHAT						AT COUNTRY?						
ransi	NE	2223 Ross	O ADMED									ed States				
attending physician. se as the burial-tran		1 Never Married 2 X N		12. WAS DECEDEN FORCES? 1 IF YES, GIVE V	YES 2	NO R	ARMED 13. WAS DECENDENT OF HISPANIC (II yes, specify Cuban, Mexican, P 1 YES 2 NO Specify:						or No-	Black,	- American Ind White, etc.	ian,
ending as the	ЭВУ	3 Widowed 4 Divorce	- 11	1954	- 195	8				Specif	ecity: Spe				Black	
or after	TED	(Specify only	DENT'S EDUC	completed)		(Give kind of	work done	during me	ON ost of world	ng	161	. KIND OF BU	SINESS/INDI	USTRY		
hospital of tached for	PLE	Elementary/Secondary (0-1	12)	College (1-4 or 5	+)	Dist			1000			прс	т	IIama		
by the hospital or att be detached for use at once.	COMPLET	17. FATHER'S NAME (First, Mid				DISC	LICE	Malla		HER'S NA		H.F.S.		none	ywell	
	BE 0			A. Bowle	S				100.004			el L.				
be retained to 5 should to notified a	2	Patricia H. Bowles 196. MAILING ADDRESS (Street and Number or Flural Route Number, City or Town, State, Zip Code) 2223 Ross Court, Silver Spring, Maryland											20910			
2 2 2		20a. METHOD OF DISPOSITIO 1 X Burlal 2 Cremation 4 Donation 1 Other (S	3 🗆 Remo	oval from State	cemeter	ACE AND DATE y, cremetory or ryland	other place)		m. 1	2 1/6 /		cation — c elten			
in are death. Page 6 m n by the fumeral director, minoral		22. NAME AND ADDRESS OF FACILITY McGuire Funeral Service Inc. 7400 Georgia Ave., N.W., Wash., D.C. 20012														
after of months		23. PART I. Enter the dis	eases, or c	omolications the	t couned th	e death Do	pot ente	400	Geor	gia	Ave.	, N.W.,	Wash.	,D.C		
y filed or floor, or the me		aflock, or her IMMEDIATE CAUSE (Fina Alterase or condition resulting in/death)	art faiture. I	Car	cinoma	une. a of Lu	ung			nig, out		or reap	ratory arre	,	Approxim Interval B Onset and 4 Mos	Batween d Death
D 0 1 6	z	DUE TO (OR AS A CONSEQUENCE OF):														
n be en	CATIC	Sequentially list condition if any, leading to immedicause. Enter UNDERLYIN CAUSE (Disease or Injury	iate IG	DUE TO	(OR AS A CO	NSEOUENCE (OF):									
th certifical tending phy at Hygens p or other	ERTIFICATION	that initiated events resulting in death) LAST		DUE TO	(OR AS A CO	NSEOUENCE (OF):									
that the demed by the med by the med Menta	ō	PART II. Other significant	t condition	s contributing to	deeth but r	not resulting	in the u	nderlyin	g cause (given in	Part I.	24a. WAS AN		24b. Y	WERE AUTOPSY F	INDINGS
uires that i signed by Health and	MEDICAL											PERFOR			WAILABLE PRIOR COMPLETION OF (OF DEATH?	
requires been signe c. of Health	ME														YES 2	NO
has been bept. of in 23 sho	AN	DID TOBACCO US 25. WAS CASE REFERRED TO		RIBUTE TO CA					UNC	ERTAI	N 🔲					
SICIAN: The law certificate has 1 the State Dept 1, or item 23	SICI	EXAMINER?	MEDICAL	HOSPITAL:		PLACE OF DE	OTHE	R:	. 5					-		
SICIA certif th the d, or	PHYSICIAN:	27. MANNER OF DEATH		28a. DATE OF	INJURY	28b, TH	ME OF	28c. INJ		esidence		CRIBE HOW I	NJURY OCC	URED		
DING PHYS After this of death with	ВУР	1 Natural 5 Pr	ending rvestigation	(Month, D	ey, rear)	II.	JURY M		YES 2] NO						
TTENDI TOR: A after d			ould not be etermined	28e. PLACE O building,	etc. (Specify)	At home, farm,	street, lac	tory, offic	•		281. LOC City	ATION (Street a or Town, State)	and Number (or Rural Ro	ute Number,	
AL OR AL DIR 2 hour 1 item	COMPLETED			CIAN: To the best of R: On the basis of e											and manner as s	stated.
To the hospit To the Funera De filed within 7 IMPORTANT:	TO BE (SIGNATURE AND TITLE OF	my	amor						2330					Month, Day, Year) 4,1995	
		30. NAME AND ADDRESS OF TO VICTOR Prie						#20) Pa	o ku	11.	Marul	and (20252		
		31. DATE FILED (Month, Day, Ye DEC 05	year y	32. REGISTRA	din la	ne robabb	- 1100	11 6		V A V	وعالك	Hary.	anu /	.00,52		
,		N== 1100000 == 100		0						_			-		_	

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE **CERTIFICATE OF DEATH**



BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

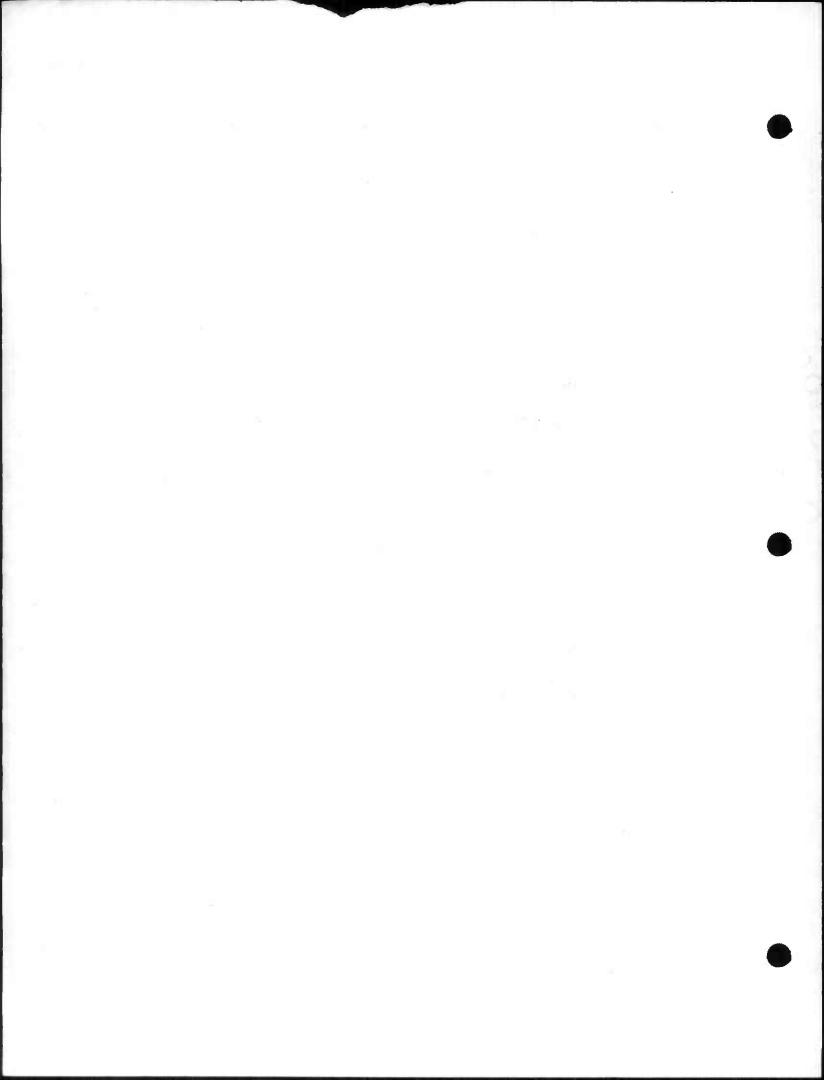
TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunal-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to bunial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND / DEPARTMENT	OF HEALTH AND MENTAL	HYGIENE
CERTIFICATE	OF DEATH	REG. NO.

	FOR STATE REGISTRAR	STATE OF MARYLA	AND / DEPARTI			MENTAL	HYGIENI REG. NO.			00.0	
i	1. DECEDENT'S NAME (First, Middle, Last) GENEVIEVE	Quinn		ARBO		MONTH	OF DEATH		YEAR 3.	2.25A M	
	4. SOCIAL SECURITY NUMBER 497-24-9698	(Month Day Year)							8. BIRTHPLACE (State or Foreign Country) Indiana		
HO	99. FACILITY NAME (If not institution, give a Suburban Hospita		9	Bethes	EATH		9c. COUNT		н		
DIMECTOR	RESIDENCE OF DECEDENT 10e. STATE 10b. COUNT			TOWN OR LOCAT	ON				10	d. INSIDE CITY LIMITS?	
	10e. STREET AND NUMBER	tgomery	Gai	thersbu	ZIP CODE			1 ℃ YES 2 ☐ NO 10g. CITIZEN OF WHAT COUNTRY?			
FUNEHAL	301 Russell Aven	UE 12. WAS DECEDENT EVER IN FORCES? 1 YES			20877 ENDENT OF HISPAN colfy Cuban, Mexica				4. RACE -	States American Indian, Phila, atc.	
ED BY	1 Never Married 2 Married 3 Widowed 4 Divorced 15. DECEDENT'S EDU	IF YES, GIVE WAR OR DA	ATES "	1 TYES	2 X NO Specif	y:			Specify: Whi		
COMPLEIE	(Specify only highest grade		(Give kind of wor life. Do NOT use in	k done during mo:	N It of working		ade Pu				
Š	17. FATHER'S NAME (First, Middle, Lest)	4	LUICUI		1a. MOTHER'S NA		_		CTOIL	5	
_	James F. Quin	n			Mary		Sheeha				
O BE	19a. INFORMANT'S NAME (Type/Print)		19b. MAILING A	DDRESS (Street a	nd Number or Rural				lode)		
-	Dianne & Perry S	eiffert	8213 Ke	ntbury	Drive, E	3ethe	sda, M	ID 208	14		
	20a. METHOD OF DISPOSITION 1	novel from State C	PLACE AND DATE OF place, cremetory or pithe Nesapeake	oisposition(Na or place) Cremat	me of Ory	12-		tsvil		Stata Maryland	
	21. SIONATURE OF FUNERAL SERVICE LI	CENSEE Ray	P	Rapp F	uneral S st Avenu	Servi	.ces, F	. A.			
NON	23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrest, shock, or heart fallure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) ASPIZATION PREUMONIA DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):										
CERTIFICATION	cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST d.										
MEDICAL	PART II. Other significant condition Dehydratio ACTIVEL MEIS DID TOBACCO USE CONT	n Dementio		in the underlying cause given in Part i. 24a. WAS AN PERFOI 1 YES :					CC	ERE AUTOPSY FINDINGS MILABLE PRIOR TO MPLETION OF CAUSE F DEATH? YES 2 NO	
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLACE OF DEATH	(Check only one)							
<u>ה</u>	1 TYES 2 NO	1 Dinpatient 2 ER/Outp	petient 3 DOA 4	☐ Nursing Hom	e 5 🗆 Realdence	a 🗆 Othe	r (Specify)				
BY PH	27. MANNER OF DEATH 1 Netural 5 Pending 2 Accident Investigation	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME INJUI	RY WO	URY AT RK? 'ES 2 NO	28d. DES	CRIBE NOW I	NJURY OCCU	JRED		
	3 Suicide a Could not be 4 Homicide datarminad	28a. PLACE OF INJURY building, atc. (Spec	— A1 home, farm, atr	eet, factory, offic			ATION (Street a or Town, State)	ind Number o	r Rural Rout	e Number,	
COMPLEIED	onel	SICIAN: To the beat of my know IER: On the beats of examination								nd manner as stated.	
- 1	290-BIGNATURE AND TITLE OF CERTIFIE	ER .			29c. LICENSE NU	MBER		29d. DATE	SIGNED (M	onth, Day, Year)	
O BE	Clum S. 7h	adarany	MD		D39	166	,	> De	cemb	par4,1995	
=	30. NAME AND ADDRESS OF PERSON W ALVINS, MADAR	HO COMPLETED CAUSE OF DE	ATH (ITEM 27) (Typo, P 5530 WI	rint) SCONSII) Ave#		Chevy				
	31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGN									



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		1 - FOR STATE REGISTRAR	STATE OF MARYLA	ND / I	DEPARTMEN RTIFICAT	T OF I	HEALTH AND	MENTA	L HYGIEN	E		
		1. DECEDENT'S HAME (First, Middle, Lest)	L		BUI	NEN	I JR.	2. DATE	OF DEATH	19	YEAR 3	7.30 A M
		220-84-6600	5. SEX 6. AGE (In 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		birthday) IF UND YRS. MONTHS	ER 1 YEAR	IF UNDER 24 HRS. HOURS MIN.	7. DATE (Month	OF BIRTH	964	8. BIRTHPL Country) Conr	ACE (State or Foreign
2, 3 should	стоя	99. FACILITY HAME (If not Institution, give atre Shady Grove Adv		spi			or Location of C kville	EATH		9c. COUI	ITY OF DEA	
Pages 1	DIREC	10a. STATE 10b. COUHTY			10c. CITY, TOWN							0d. INSIDE CITY LIMITS?
permit. P		Maryland Monto	gomery		Ro	ckvi	. LIE			100 0171		X YES 2 □ NO
t te	ER/	#19 Clemson Co	ourt.				20850				J.S.A	
MARYLAND 21215-0020 retained by the hospital or attending physician. 5 should be detached for use as the burial-transit notified at once.	BY FUNERAL		12. WAS DECEDENT EVER IN L FORCES? 1 YES IF YES, GIVE WAR OR DAT	DENT EVER IN U.S. ARMED 1 YES 2 NO 11 yes,			S DECEMBENT OF HISPANIC ORIGIN? (Specify Yes of sea, specify Cuban, Mexican, Puerto Rican, etc.) YES 2 X NO Specify:					- American Indian, White, etc.
	9	15. DECEDENT'S EDUCA (Specify only highest grade co	TION 1	(Ghu	EDENT'S USUAL	e durina mo	OH ost of working	168	. KIHD OF BUS	HESS/IHD		
	APLET	Elementary/Secondary (0-12)	College (1-4 or 5+) 3 Yrs	IIIa. L	Studen)			Non	e		
	COMPL	17. FATHER'S HAME (First, Middle, Last)					18. MOTHER'S N	AME (First,	Middle, Malden	Sumame)		
	BE (William L. 19a. INFORMANT'S HAME (Type/Print) / T	Bowen Sr				Je		Bunch			
	2	Mr William L. Bo	Father) Owen Sr.	196.			and Number or Rural					0.850
TIMORE, I Page 6 may be ral director, page i		20a. METHOD OF DISPOSITION 1 M Burlet 2 Cremation 3 Remove	20b. P	LACEAN	D DATE OF DISPO	SITION (No	ame of	OAT	-		City or Town	
Tech Fe		4 Donation 5 Other (Specify)	Ga	ite			Cem.		/9 Si	lver	Spr	ing,Md
SAL r death re fune al.		Sexe R.	Lunde	_	_	Snow	den Fui	nera	ton c	+ RC	ckvi	0850 lle, Md
hours after of filled in by the on, or removal.		23. PART I. Enter the diseases, or co- shock, or heart fellure. Li IMMEDIATE CAUSE (Final	mplications thet caused t at only one cause on eec	the dest	th. Do not ente	or the mo	ode of dying, suc	ch aa cen	disc or respi	ratory srr	est,	Approximats Interval Between Onset and Daath
completely file ial, cremation, event, the		disease or condition resulting in death)	DUE TO (OR AS A C		RATION	1						IDAY
ST EN GO	NO	Environment of the control										6 WEEKS
certificate be rounding physician Hygiene prior the traus	ERTIFICATION	if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in desth) LAST		11	mmun	CY	y syndrome			3 MONTHS		
~ > < -	O	PART II. Other aignificent conditions	contributing to deeth but	not res	sulting in the a	ınderivin	g ceuse given in	Part I	24s. WAS AN	ALITODEV	T 245 W	ERE AUTOPSY FINDINGS
that than	MEDICAL	BAAIN HERNIA	NSM				g codes givenin		PERFOR	MED?	A O	MAILABLE PRIOR TO OMPLETION OF CAUSE F DEATH?
F 0 9 0 5		DID TOBACCO USE CONTRI		DEAT	U VEC 🗆	NO F	LINICEDTAL				1	☐ YES 2 ☐ NO
AL has the Dept 23	SICIAN	25. WAS CASE REFERRED TO MEDICAL			OF DEATH (Chec		UNCERIAI	N L				
CLAN: The ertificate I the State	SIC		10SPITAL:	lent 3	DOA 4 N		ig Home 5 Residence 6 Other (Specify)					
PHYSIC this ce with th	ву РНУ	27. MAHHER OF DEATH 1 Natural 5 Pending Investigation	28a. DATE OF IHJURY (Manth, Day, Year)		26b. TIME OF INJURY M	WC	URY AT DRK? YES 2 HO	26d, DES	CRIBE HOW IN	JURY OCC	URED	
TTENDII TTOR: A after de		2 Accident Investigation 3 Suicide 6 Could not be detarmined	e, farm, street, fa	ctory, offic					te Number,			
TAL OR ZZ Hour	COMPLETE		AN: To the beet of my knowled On the beels of exemination s									nd manner as stated.
THE HOSPITAL THE FUNERAL filed within 72 PORTANT: If		29b. SIGNATURE AND TITLE OF CERTIFIER					opinion, death occured at the time, data end place, and due to the cause(a 29c, LICENSE NUMBER 29d, DATE SIGNED					
TO THE De filed IMPOR	TO BE	M.D	•				D35	941				ER 7 1995

W. KOMONGTON



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PURAN 31. DATE FILED (MONTH, Day, Year) DEC 08 1995

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

MATHUR
32. REGISTRAT'S SIGNATURE
Charles Ravidal

#401

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burlat-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burlat, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BALTIMORE, MARYLAND 21215-0020

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAR		CER	TIFIC	ATE OF	DEAT	Ή	RE	G. NO.			
1. DECEDENT'S NAME (First, Middle, Lest) Quon Shee Mar Born 2. Date C									EATH	,	YEAR	3. TIME OF DEATH
	Quon Shee MAR Born						1	ecembe	r 5.	199		7:45 a. M
	570 54 5040		(In yrs. lest bir		UNDER 1 YEAR	HOURS	24 HRS.	7. DATE OF BI (Month, Dey, DEC. 1	RTH (bar) 1	903	CH COUNTRY	PLACE (State or Foreign INA
	9a. FACILITY NAME (If not institution, give street	and number)		91	. CITY, TOWN	CITY, TOWN OR LOCATION OF DE			<u> </u>			ATH
OR	WASHINGTON ADVENTIS	L		TOKOMA	PARK				MONTO	OME	RY	
DIRECTOR	RESIDENCE OF DECEDENT 10a, STATE 10b, COUNTY	1	IOC. CITY, TOWN OR LOCATION							10d. INSIDE CITY		
H	MARYLAND MONTGO	MEDV	- 1	BETHESDA						LIMITS?		
	100. STREET AND NUMBER	FIERI		DEIII		of. ZIP CODE				10g. CITIZI	HAT COUNTRY?	
ERA	6114 WALHONDING RO		20816									
FUNERAL		IN U.S. ARMEI	D		CENDENT O	IT OF HISPANIC ORIGIN? (Specify Yea or No-					- American Indian,	
BY F	1 Never Married 2 Married 3 Widowed 4 Divorced	FORCES? 1 TYES				S 2 X NO		n, Puerlo Rican,	etc.)		Specif	, White, etc.
	15. DECEDENT'S EDUCATION	ON	18a, DECE	DENT'S US	UAL OCCUPAT	TION		16b. KINE	OF BUSI	INESS/INDU	ISTRY	HOZIN
1	(Specify only highest grade com	pleted)	(Give i		done during i		g	Tour Kine	01 903	11/235/11/00	JIM	
7	Elementary/Secondary (0-12) Co	ollege (1-4 or 5 +)	SELF	EMP	LOYED			RES	TAUR	ANT		
COMPLETED	17. FATHER'S NAME (First, Middle, Last)					16. MOTH	IER'S NAI	ME (First, Middle	, Maiden S	Sumame)		
BE C	PETER FONG					U	NKNO	WN				
TO B	19a, INFORMANT'S NAME (Type/Print)		19b. M	IAILING A	DRESS (Stree	and Number	or Rural R	loute Number, Cl	ty or Town	, State, Zip (Code)	
F	GENE BORN		221	1 RE	DDFIEL	D DR.	FAL	LS CHU				
	20e. METHOD OF DISPOSITION 117 Burlai 2 Cremation 3 Removal	from State	b. PLACE AND	lance or other	nlanal			1		CATION — C		
	4 Donation 5 Other (Specify)		GEÓRGE	WAS	HINGTO			12/8	ADEL	PHIA	, MD	•
	21. SIGNATURE OF FUNERAL BEHINGE TICKNEY 22. NAME AND ADDRESS OF FACILITY JOSEPH GAWLER'S SONS, INC. 200									20016		
	I have	M00856			5130	WISCO	NSIN	AVE.	N.W.	WASI	HING	TON, D.C.
	23. PART I. Enter the diseases, or com shock, or heart failure. List			n. Do not	enter the n	ode of dyl	ng, suci	h aa cerdiec	or reapir	retory arre	ent,	Approximate Interval Between
	IMMEDIATE CAUSE (Fine)	Reno	01	I.	.40							Onset and Death
	disease or condition resulting in death)	Keno	A COMMEQUE	_	vice.							7
_	_	DUE TO (OR AS	A COMMEOUE	INCE OF):								Scharjes
CERTIFICATION	Sequentially list conditions,	Sequentially list conditions, If any, leading to immediate										
CAT	cause. Enter UNDERLYING CAUSE (Disease or Injury											
TE	that initiated eventa	DUE TO (OR AS	A CONSEQUE	ENCE OF):								
ER	resulting in death) LAST											
	PART II. Other algnificant conditions co	ontributing to death	but not res	ulting in	the underly	ing cause o	given in	Partel. 24a.	WAS AN		24b.	WERE AUTOPSY FINDINGS
DICAL	Li	refuc		ent	KS	Acci	den	43 15	PERFORI			AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
MED		58/250	\$.						, , , , ,			1 YES 2 NO
	DID TOBACCO USE CONTRIB	UTE TO CAUSE	OF DEATH	YES	□ NO	M UNC	ERTAIN	<u> </u>				
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	OSPITAL:	26. PLACE		(Check only or	0)						
YSI		Theatlant 2 ER/Ou	rtpetient 3 🗆		THER:	oma 5 🗆 Ra	aldenca	8 Other (Spe	ecify)			
PH	27. MANNER OF DEATH 1 Netural 5 Pending	26a. DATE OF INJURY (Month, Day, Year)		Bb. TIME (Y	NJURY AT VORK?		28d. DESCRIE	E HOW IN	JURY OCC	URED	
ВУ	2 Accident Investigation	28e, PLACE OF INJUR		4		YES 2	NO		1 101	4.81 -1.		
0	3 Suicide & Could not be 4 Homicide determined	building, etc. (Sp		, rarm, seri	et, rectory, or	rica		28f. LOCATION City or Tox		nd Number (or Humai H	soure Number,
	29a. CERTIFIER											
City or Town, State) 29a. CERTIFIER (Check only one) 29a. CERTIFIER (Check only one) 29b. CERTIFIER (Check only one) 29b. CERTIFIER (Check only one) 20b. CERTIF) and manner ea stated.			
S	296. SIGNATURE AND TITLE OF CERTIFIER	ev ant	- le			29c. LICI	ENSE NUM	MBER	1	29d. DATE	SIGNED	(Month, Day, Year)
BE	1	MAL	MI			02	42	83				
5	30. NAME AND ADDRESS OF PERSON WHO C	OMPLETED CAUSE OF I	EATH (ITEM 2	27) (Type, P	jiii) D	D	1	83 mse	D 4	10 -		
	30. NAME AND ADDRESS OF PERSON WHO C	SO Fort	me	ad	e K	cad	6	mil	1	e d	E 72	7
	31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIG	GNATURE									
	DEC 07 1995	Jelia at wel	sorked	AH								
				_								DHMH. 16 Bay 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 68760

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TO THE HOSPITAL OR ATTENDING PHYSICIAN; The law requires that the death certificate be executed	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and com	within
뿔	置	filed
2	2	9
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-	2	

1 - STATE REGISTRAR	STATE OF MARYL	AND / DEPARTM CERTIFIC	IENT OF HEALTH AN	D MENTAL HYG					
1. DECEDENT'S NAME (First, Middle, Last	Buck			2. DATE OF DEAT	H DAY	YEAR 3. TIME OF D	EATH M		
4. SOCIAL SECURITY NUMBER 577-72-6449 98. FACILITY NAME (If not institution, give	1 🗶 M 2 🗌 F	41 YRS. MOI	UNDER 1 YEAR OF UNDER 24 HR NTHS DAYS HOURS MIN	Jan 12	1954	8. BIRTHPLACE (State of Country) Washington			
Hyattsville Mano RESIDENCE OF DECEDENT 10s. STATE Maryland Hyattsville Mano RESIDENCE OF DECEDENT 10s. STATE 10s. COUN Print			Hyattsville,			nce George	es		
Maryland Prin	ce Georges		own or Location attsville, Ma	ryland	10d, INSIDE CITY LIMITS? 1 V YES 2 \(\sigma \)				
10e. STREET AND NUMBER 6500 Riggs Road 11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced			10f. ZIP CODE 20	743		en of what country			
11. MARITAL STATUS 1 Never Merried 2 Merried 3 Widowed 4 Divorced	12. WAS DECEDENT EVER II FORCES? 1 YES	2 NO	13. WAS DECENDENT OF HIS If yes, specify Cuben, Me 1 YES 2 NO Sp	kican, Puerto Rican, etc	y Yes or No—	14. RACE — American I Black, White, atc. Specify: Black			
15. DECEDENT'S ED (Specify only highest grate Elementary/Secondary (0-12) 12 17. FATHER'S NAME (First, Middle, Lest) Marion Fuggers	DUCATION de completed) College (1-4 or 5+)	16a, DECEDENT'S USU (Give kind of work life. Do NOT use rel	done during most of working tired.)		BUSINESS/INDU				
	2			NAME (First, Middle, Ma e Henderso		idustry			
190. INFORMANT'S NAME (Type/Print) Marian Buck		ral Route Number, City of	Henderson (Route Number, City or Town, State, Zip Code) shington, D.C. 20020						
20s. METHOD OF DISPOSITION 1 Burlet 2 Cremation 3 Rev 4 Donation 5 Other (Specify)		D. PLACE AND DATE OF DI netery, cremetory or other p	place)	DATE 200		ty or Town, Stata			
21. SIGNATURE OF FUNERAL SERVICE L			22. NAME AND ADDRESS OF Alexander S 5538 Marlbo	Pope Fur	neral Ho	omes			
23. PART I. Enter the diseases, or shock, or heart failure IMMEDIATE CAUSE (Final disease or condition resulting in deeth)	ACQUIRED	ech line.	ICIENCY SYNDE		eapiratory arre	Interval Onset	imata i Batween and Death NOWN		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING	b	DUE TO (OR AS A CONSEQUENCE OF):							
CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (OR AS A	CONSEQUENCE OF):							
PART II. Other algorificant conditions PNEUMONIA, PANO	one contributing to death b	ut not resulting in th	ne underlying cause given UROPATHY	PER	BAN AUTOPSY RFORMED? S 2 1 NO	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 0 NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:		26. PLACE OF DEATN						
1 YES 2 XXO	1 Inpatient 2 ER/Outp		HER: Nursing Home 5 - Residen						
1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK? M 1 YES 2 NO	28d. DESCRIBE NO	W INJURY OCCU	IRED			
3 Suicide 6 Could not be 4 Nomicide determined	28e, PLACE OF INJURY building, etc. (Spec	— At home, farm, street	t, factory, office	281. LOCATION (Str City or Town, S	eet and Number or Rural Route Number, late)				
	SICIAN: To the best of my know						e stated.		
29b. SIGNATURE AND TITLE OF GERTIFIE	MIST	M	29c, LICENSE I DO 149	NUMBER		ember 7,			
30. NAME AND ADDRESS OF PERSON W LEWIS HILLIARD DE			GREENBELT RO	OAD #U-1 C	OLLEGE	PARK, MD	20740		
31. DATE FILED (Month, Day, Year) DEC 8 199	5 Jalia David	ATURE CANAL							

050 R 1895 February 134

BALTIMORE, MARYLAND 21215-0020	hours after death. Page 6 may be retained by the hospital or attending physician.	THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should in filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremitation, or removal.	e medical examiner must be notified at once.
DIVISION OF VITAL RECORDS, P.O. BOX 68760	THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within-TA hours after death. Page 6 may be retained by the hospital or attending physician.	THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral direct of the within 72 hours after death with the State Dept, of Health and Mental Hyglene prior to burfal, cremation, or removal.	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

	1. DECEDENT'S NAME (First, Middle, Las)							2. DATE OF DEATH		1	. TIME OF DEATH
	Marion Kurfees B	elt							December	7. 1	985	8:27 A. M
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. les	st birthday)	IF UNDE	R 1 YEAR	IF UNDE	R 24 HRS.	7. DATE OF BIRTH		8. BIRTHPL	ACE (State or Foreign
	218-01-3646	1 □ M 2 ★ F	85	YRS.	MONTHS	DAYS	HOURS	MIN.	(Month, Day, Ybar) April 1, 1	910	Wash	ington, DC
	9a. FACILITY NAME (If not institution, give	street and number)			9b. CIT	Y, TOWN	TOWN OR LOCATION OF DEATH Sc. COUNTY OF DEATH					
R R	Washington Adven-	tist Hosp	ital		Takoma Park					Montgomery		
DIRECTOR	RESIDENCE OF DECEDENT 10a. STATE 10b. COUN			T 40 .00	Y, TOWN OR LOCATION					11011		
=											1	Od. INSIDE CITY LIMITS?
	Maryland Me	ontgomery			Rock							YES 2 NO
FUNERAL						10	r. ZIP COD					AT COUNTRY?
=	4904 Adrian Stre		T EVED IN ILE AD	MED	140	W00 D56	2085				S.A.	
	IF YES, GIVE WAR OR DATES 1 YES 2 XT NO Specify: Specify:										- American Indian, Whita, atc.	
	D 3 ☑ Wildowed 4 □ Divorced IF YES, GIVE WAR OR DATES 1 □ YES 2 ☑ NO Specify: White										White	
COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed) (Give kind of work done during most of working											
19	Elementary/Secondary (0-12)	College (1-4 or 5	+) /// /// /// /// // // // // // // // /	. Do NOT u	se retired.)	during me	IST OF WORK	'U				
M P	12		LP	Nurs	е				Medi	ca1		
	17. FATHER'S NAME (First, Middle, Last)								ME (First, Middle, Malden			
BE	(First Unknown)	Turner							ma11	4 -	
2	19a. INFORMANT'S NAME (Type/Print) Neil M. Belt								Noute Number, City or Town			0.0
	20a. METHOD OF DISPOSITION	-						а, н	yattsville			
	1 To Burial 2 Cremation 3 Re 4 Donation 5 Other (Specify)	moval from State	cemetery, cre	metory or c	of DISPO	SITION (Ne	ame of	1	2/11/1995	CATION —	City or Town	, Stata
	21. SIGNATURE OF FUNERAL SERVICE	JCENSEE	- Irort	LIRC	22.	NAME AL	NO ADDRE	SS OF FA	CILITY			
	· Clarin	1 0	0001			Fran	cis	Gasc	h's Sons F			
_	Marie	1+.19	ell f			B al	timo	re A	venue, Hya	ttsv	ille,	Md. 20781
	23. PART I. Enter the diseases, or shock, or haert failure	Complications the List only one car	it caused the de use on each line	iath. Do i i.	not ente	the mo	de of dy	ing, aucl	n aa cardiac or reapi	ratory ar	reat,	Approximata interval Between
	IMMEDIATE CAUSE (Final disease or condition	A		,								Onset and Death
	resulting in death)	1-10R1	16) TE	100	15							54RS
		OUE TO	(OR AS A CONSE	DUENCE O	F):							
CERTIFICATION	Sequantielly list conditions, if any, leading to immediate	b	(OR AS A CONSEC	DUENCE O	F):	_						+
\ F¥	cause. Entar UNDERLYING											į l
Ē	CAUSE (Disease or injury thet initiated events	DUE TO	(OR AS A CONSEC	DUENCE O	F):							
E	resulting in death) LAST	d										
	PART II. Other aignificent condition	ena contributino to	death but not r	eeuiting	In the m	nderlyln.	n course	ni naula	Part I. 24s. WAS AN	ALITORAL	T 0.45 W	
AEDICAL				ovaiting	m and on	idottytti	8 canae	given in	PERFOR	MED?	A	ERE AUTOPSY FINDINGS MILABLE PRIOR TO OMPLETION OF CAUSE
						_	_		1 YES 2	NO	0	F DEATH?
-	DID TOBACCO USE CON	IPIRI ITE TO CA	LISE OF DEA	TLI VI	:c 🖂	NO F	LINIC	ERTAIN			1	YES 2 NO
AN	25. WAS CASE REFERRED TO MEDICAL	INIDOIL TO CA		E OF DEA			1 OIAC	EKIAII	1 🗆			
Sic	EXAMINER?	HOSPITAL:	ER/Outpatient 3		OTHE	R:	D	ridence	8 Other (Specify)			
PHYSICIAN	27. MANNER OF DEATH	26a, DATE OF	INJURY	28b. TIM	E OF	28c. INJ	URY AT	siderice	28d. DESCRIBE HOW IN	JURY OC	CURED	
ВУР	1 Natural 5 Pending	(Month, L	ray, Year)	IN.	JURY M		RK?	NO				
0	2 Accident investigation 3 Suicide 6 Could not be	28a. PLACE C	F INJURY — At he etc. (Specify)	me, farm,	atreet, fac	tory, offic	•		26f. LOCATION (Street a	nd Number	or Aurai Aou	te Number,
ш	4 Homicide determined	- Conting	www. (upacity)						City or Town, State)			
12	29a. CERTIFIER 1 CERTIFYING PHY	SICIAN: To the best of	my knowledge, de	ath occurr	ed at the	lme, data	and place	and due	to the cause(s) and man	ner as sta	led.	
COMPLET									time, data and place, and			nd manner as stated.
U U	29b. BIONATURE AND THE OF CERTIFI							ENSE NUM				Ionth, Day, Year)
00	Jem	MI					1)	20:	391	DA	16001	03 1991
2	30. NAME AND AGORESS OF PERSON W	HO COMPLETEO CAU	SE OF OEATH (ITE	M 27) (Type	, Print)	7	0 -			1	CC 70) (1	-1, 1/3
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	THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within Z4 hours after death. Page 6 may be retained by the host	TID THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detache		IMPORTANT: if Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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	E O	E O	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	를
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	1. DECEDENT'S NAME (First, Middle, Last)						E OF DEATH			3. TIME OF DEATH	\neg	
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	4. SOCIAL SECURITY NUMBER	5. SEX 8. AGE	(In yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DAT	E OF BIRTH	T		PLACE (State or Foreign	\dashv	
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	9e. FACILITY NAME (If not institution, give	street and number)		9b. CITY, TOWN	OR LOCATION OF D				NTY OF D		\dashv	
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RE	10e. STATE 10b. COUNT	Υ	10c. CITY,	TOWN OR LOCA	TION					10d. INSIDE CITY	┪	
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	Nancy Jane Brady				enue, Sp							
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32. REGISTRAR'S SIGNATURE

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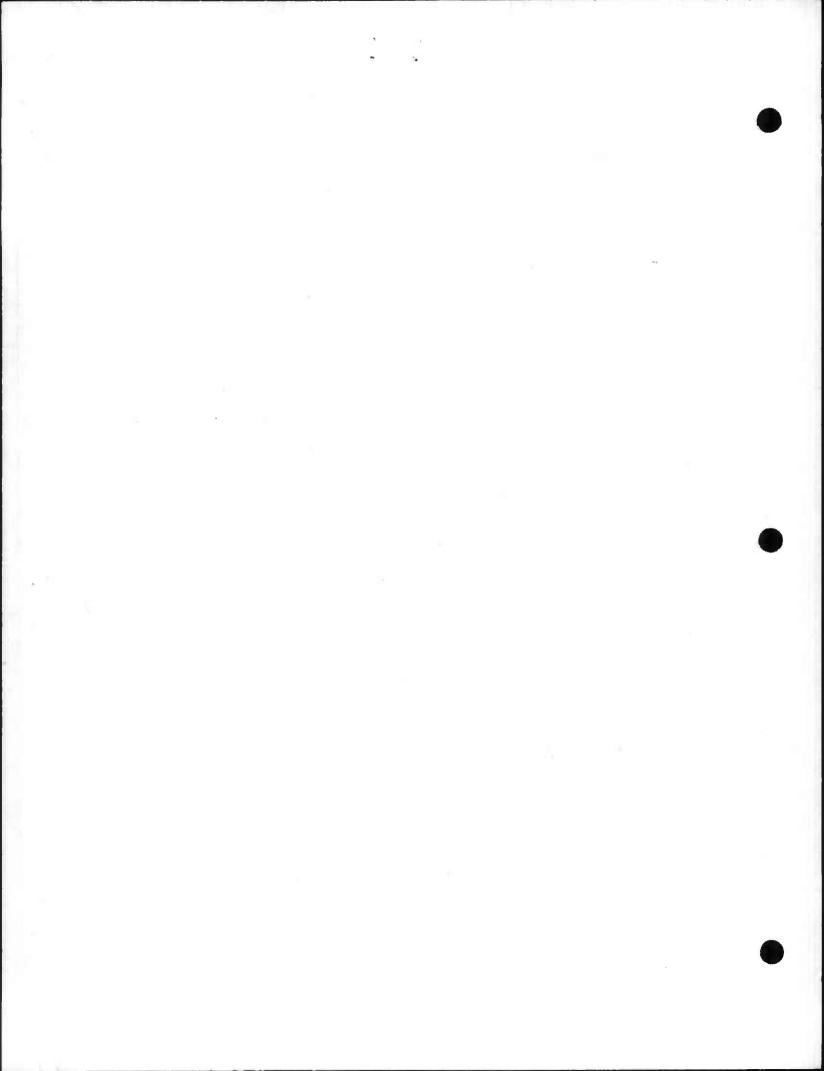
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FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (FIT MICHE, Last) 2. DATE OF DEATH Miller Brown YOU'V 1995 2285m :34 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year) 02-21-1929 MONTHS DAYS HOURS 217-26-8454 1 M M 2 | F 66 YRS Tenn. 9s. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF GEATH 9c. COUNTY OF DEATH DIRECTOR Harford Memorial Hospital Havre de Grace Harford RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MD Harford Aberdeen 1 X YES 2 | NO 10e. STREET AND NUMBER FUNERAL 10g. CITIZEN OF WHAT COUNTRY? 601 Cornell Street, Apt. 311 21001 USA 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS OECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 YES 2 NO Specify: 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Married BY 3 X Widowed 4 Divorced White COMPLETED 16a. DECEDENT'S USUAL OCCUPATION

"This kind of work done during most of working 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16b. KINO OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5 +) 8 Farmer Agriculture 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Malden Surname Homer Brown BE Mattie Dowell 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING AODRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Mrs. Betty A. Stanyard 214 S. Washington St., Havre de Grace, MD 21078 20a. METHOD OF DISPOSITION

1 X Burlal 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION — City or Town, State Conowingo Cemetery 4 Donation 5 Other (Specify) 12/4 Conowingo, 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Mitchell-Smith Funeral Home, P.A. Havre de Grace, MD 21078-3197 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate ahock, or heart fallure. List only one cause on each line. IMMEDIATE CAUSE (Final Onset and Death disease or condition reaulting in death) lears lang CERTIFICATION Sequentielly list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury 02 that initiated events resulting in deeth) LAST PART II. Other algorificent conditions contributing to death but not resulting in the underlying cause given in Part I. 24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE 24a. WAS AN AUTOPSY PERFORMEO? MEDICAL Lers ulmona 1 TES 2 NO OF DEATH? 1 TES 2 ND DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES 💢 NO 🗆 UNCERTAIN 🗆 PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE DF DEATH (Check only one) HOSPITAL: OTHER: 1 TES 2 NO Inpetient 2 - ER/Outpetient 3 - DOA 4 - Nursing Home 5 - Residence 8 - Other (Specify) 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 286. TIME OF INJURY 26c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 Natural 1 YES 2 NO BY 2 Accident 28s. PLACE OF INJURY — At home, farm, street, fectory, office building, etc. (Specify) 3 Suicide 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 8 Could not be 4 Homicide 29a. CERTIFIER (Check only 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner se stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(s) and menner as stated. 29c. LICENSE NUMBER BE 29d. DATE SIGNEO (Month, Day, Year) M. D. 0 30. NAME AND ADDRESS OF PERSON WHD COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) LETICIA GALVEZ 625 S- union



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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

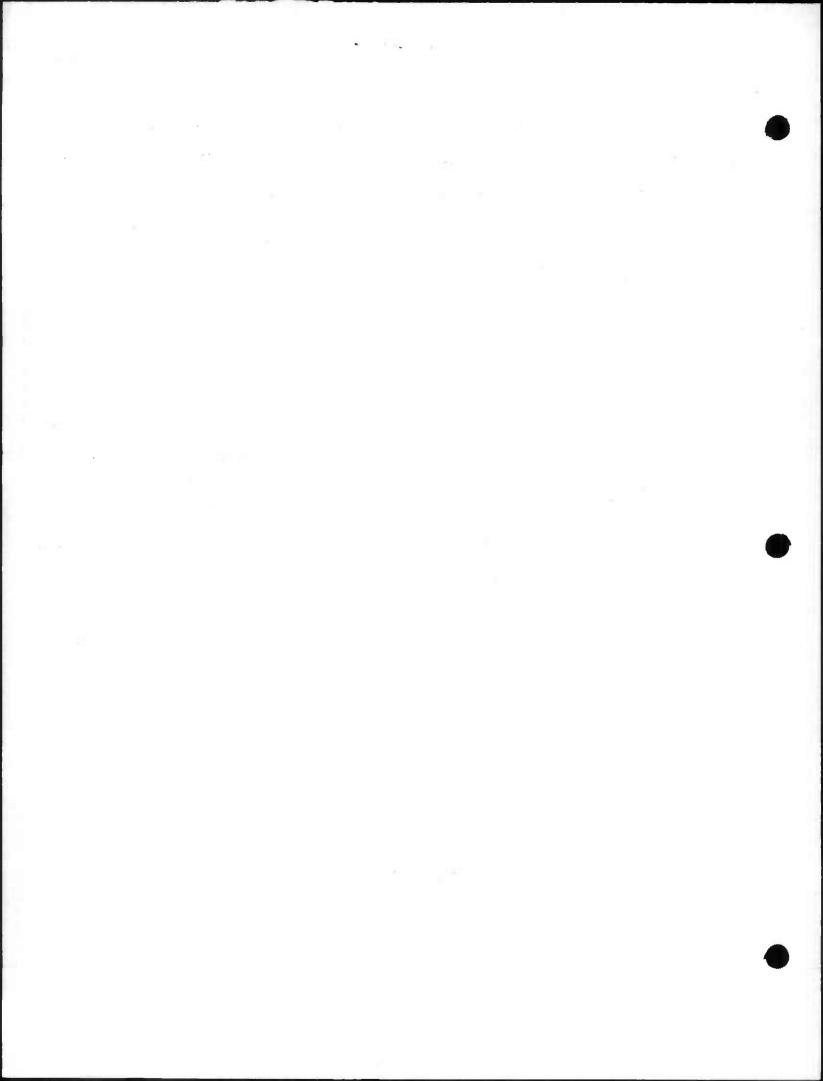
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If them 28 is marked, or litem 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

REG. NO.

-	TTEGIOTTUTT				IOAIL	. 01	DEA		HEG. NC	7.		
i	1. DECEDENT'S NAME (First, Middle, Last) RAYMOND]	BENTH	AM			2. DATE OF DEATH MONTH NOVEMBER	30,19	YEAR	3. TIME OF DEATH 1:15A M		
- 1	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs Is	st birthday)	IF UNDER	1 YEAR	IF UNDER	24 HRS.	7. DATE OF BIRTH		A DIRTUE	PLACE (State or Foreign
	267-07-4371	1 [XM 2 ☐ F	81	YRS.	MONTHS	DAYS	HOURS	MIN.	Nov. 17,	1914	Country	Maryland
	9e. FACILITY NAME (If not institution, give st	reet and number)			9b. CITY,	CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DE						ATH
DIRECTOR	THE JOHNS HO	PKINS HO	SPITAL		В	ALT	IMORI	E CIT	ſΥ	n	ı/a	
5	RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY			10.00								
#	100. STATE 106. COUNTY			10c. CIT	Y, TOWN O	R LOCAT	ION					10d. INSIDE CITY LIMITS?
ā	Maryland	Harford					lavr	e de	Grace			1 X YES 2 NO
¥	10e. STREET AND NUMBER			101	ZIP COD	E		10g. CITIZEN OF WHAT COUNTRY?				
324 North Union Avenue 21078								78		US	A	
Too. STREET AND NUMBER 324 North Union Avenue 11. MARITAL STATUS 11. Married 2 V Merried FORCES? 1 VES 2 X NO If yes, specify Cub							ENDENT (F HISPAN	IC ORIGIN? (Specify Ye	s or No-	14. RACE	— American Indian, White, etc.
BY F									Specify	v:		
	3 Widowed 4 Divorced										1	White
	15. DECEDENT'S EOUC (Specify only highest grade		(ECEDENT'S Give kind of	work done o			na	16b. KIND OF BU	ISINESS/INE	JUSTRY	
	Elementary/Secondary (0-12)	College (1-4 or 5+)		le. Do NOT u	se retired.)			5				
₩.	10			Sale	sman				Retai	Sale	25	
COMPLETED	17. FATHER'S NAME (First, Middle, Lest)						16. MOT	HER'S NAI	ME (First, Middle, Meider	Surname)		
BE	Harold A. Benth	am					Da	isy	Bauer			
6	19e. INFORMANT'S NAME (Type/Print)		- 1	9b. MAILING	ADDRESS	(Street a	nd Numbe	or Rurel F	Route Number, City or Tox	vn, State, Zip	o Code)	
	Mrs. Joyce E. B	entham		324	N. U	nio	n Av	enue	e, Havre	de G	race.	MD 21078
	20e. METHOD OF DISPOSITION 1 Description 2 Cremetion 3 Remo	mal from State	20b. PLACE	EANDDATE	OFDISPOS	TION (Na	me of			CATION -		
	4 Donetion 6 Other (Specify)	THE TOTAL STATE	Ange	Hill	Cen	ete	ry		12/2 H	avre	de C	Grace, MD
	21. SIGNATURE OF FUNERAL SERVICE LIC	EHOSE						SS OF FA	CILITY			
	►(1) Mo.	V X -	100		f	Viitc	hell-	Smit	h Funeral	Hom	ie, P	.A.
=	23. PART I. Enter the diseasee, or o	omplications that	caused the d	leeth Oo	not enter	Hav	re d	e Gr	ace MD	2107	8-310	Approximats
	shock, or heert fallure.					1110 1110	o. o,	mg, aco		andiory and		Interval Between
	IMMEDIATE CAUSE (Finel disease or condition	- 1				4						Onset and Death
1	resulting in desth)	out TO	OR AS A CONS	YTH	- W 1	4						70175
. 1							21 6	770	~1			~ 2 whs
CERTIFICATION	Sequentially list conditions,	Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF):										
AT	if sny, leading to immediate ceuse. Enter UNDERLYING		HIPPI			2 A	Tio	~				2 wks
밀	CAUSE (Diseese or injury that initiated events	W	OR AS A CONSI									
E	resulting in deeth) LAST											
CE												
AL	PART II. Other significant condition	s contributing to	deeth but not	resulting	in the un	derlyin	g csuse	given in		NAUTOPSY		WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO
EDICAL									1 _ YES			COMPLETION OF CAUSE OF DEATH?
												1 Tes 2 No
5 5	DID TOBACCO USE CONTI	RIBUTE TO CAL	JSE OF DE	ATH Y	ES 🗆 1	NO [UNC	ERTAIN	1 🔯			
M	25. WAS CASE REFERRED TO MEDICAL		26, PL/	ACE OF DEA	TH (Check	only one)						
Sic	EXAMINER?	HOSPITAL:	ER/Outpatient	3 DOA	OTHER 4 - Nun		10 5 🗆 R	eeldence	6 Other (Specify)			
PHYSICIAN:	27. MANNER OF DEATH	28e. DATE OF I		26b. TIR	IE OF JURY	26c. INJ			28d. DESCRIBE HOW	INJURY OC	CURED	
ВУР	1 Natural 5 Pending	(MONN, Da	y, rear)		M		PRK? YES 2	NO				
	2 Accident investigation 3 Suicide 6 Could not be	26e. PLACE OF	INJURY — At I	nome, term,	streat, fact	ory, offic	•		281. LOCATION (Street		r or Rural A	loute Number,
COMPLETED	4 Homicide determined	bunding, a	ntc. (Specify)						City or Town, State	")		
	29e. CERTIFIER 1 X CERTIFYING PHYSI	CIAN: To the heat of	my knowledge d	death occur	ad at the ti	me dete	and place	and due	to the enverter and ev		died.	
M	one) —											end menner es stated.
8	Α.											
BE	29b. SIGNATURE AND TITLE OF CERTIFIER	Sul	rgich	(ESI	DEN	-	29c. LIC	ENSE NUM	IBER	29d. DAT		(Month, Day, Year)
2	30. NAME AND ADDIESS OF PERSON WH	0.00100 5777					MIO	12			11 3	0 95
	30, NAME AND ADDITES OF PERSON WH	S A	JOHN!	EM 27) (Type	PLL N	1 21	tock	PITA	R BA	DMAI	EA	AN
	31. DATE FILED (Month, Day, Year)	22 DEGISTRAL	O'C PICHATURE							. ,	1	
	DEC 0 1 199		Saucher	Rardal	4							
	DE0.0 T 190				•							



retained by the hospital or attending physician. BALTIMORE, MARYLAND 21215-0020 after death. Page 6 may be

OF VITAL RECORDS, P.O.

DIVISION

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Item

31. DATE FILED (Month, Day, Y

ARGISTRAB'S SIGNATURO

DIRECTOR: /

FUNERAL I within 72 h HOSPITAL TO THE HOSPITA
TO THE FUNERA
De filed within 72
IMPORTANT: II

Pages 1, 2, 3 should permit. burial-transit as the use ğ detached once. Pe Ħ Should notified page 5 s pe must director, examiner funeral ion. or removal. medicai the cremation. completely event. executed burial, traumatic and prior to 1 physician certificate be other t attending physental Hygiene p 0 OR ATTENDING PHYSICIAN: The law requires that the death the atten and and any Signed I Shows been t. of I has be Dept. certificate h Item of the marked, this (with After

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 -CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATN 3. TIME OF DEATH 24. BRAXTON NOVEMBER 1995 PARIS 12:03 Pm 4. SOCIAL SECURITY NUMBER 7. DATE OF BIRTN (Month, Day, Year) 6. BIRTHPLACE (State or Foreign Country) 5. SEX IF UNDER 1 YEAR | IF UNDER 24 HRS. 1 🔀 M 2 🗌 F N/A 7/12/95 Maryland 4 9e. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR DOCTORS COMMUNITY HOSPITAL LANHAM PRINCE GEORGES RESIDENCE OF DECEDENT 10b. COUNT 10c. CITY, TOWN OR LOCATION 10a. STATE 10d. INSIDE CITY Maryland Rockville, MD 1 X YES 2 NO Montgomery FUNERAL 10e. STREET AND NUMBER 101. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 20851 U.S.A. 505 Linthicum Street 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ∑NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 14. RACE — American Indian, Black, White, atc. 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or Nocify Cuban, Maxican, Puarto Rican, etc.) Never Married 2 Married Specify: Black 1 YES ZXXNO Specify: BY 3 Widowed 4 Divorced ED 15. DECEDENT'S EDUCATION 16a, DECEDENT'S USUAL OCCUPATION 165 KIND OF BUSINESS/INDUSTRY (Give kind of work done life. Do NOT use retired.) ET College (1-4 or 5+) /Secondary (0-12) N/A N/A COMPL N/A 17. FATHER'S NAME (First, Middle, Last) 16. MOTNER'S NAME (First, Middle, Maiden Surname) Mary Brown Charles Braxton BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code; 2 505 Linthicum Street, Rockville, MD 20851 Charles Braxton 20a. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION -- City or Town, State DATE 1 N Burlai 2 Cremation 3 Removal from State 4 Donation 6 Other (Specify) Harmony Memorial Park Landover, MD 21, SIGNATURE OF FUNERAL SERVICE LICENSEE J. B. Jenkins Funeral Home Mimberly IUMIC 7474 Landover Road, Landover, MD 20785 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between **Onset and Death** IMMEDIATE CAUSE (Final METHADONE INTOXICATION disease or condition SUDDEN INFANT DEATH SYNDROME resulting in death) DUE TO (OR AS A CONSEDUENCE OF): CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): If any, leading to Immediate cause, Enter UNDERLYING CAUSE (Disease Dr Injury DUE TO (OR AS A CONSEDUENCE OF): that initiated events resulting in desth) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS MEDICAL PERFORMED? AVAILABLE PRIOR TO COMPLETION OF CAUSE YES 2 NO WES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES IN NO IN UNCERTAIN I PHYSICIAN: 28. PLACE OF DEATN (Check only one 25. WAS CASE REFERRED TO MEDICAL HOSPITAL . TX YES 2 NO Inpatient 2 X ER/Outpatient 3 - DOA 4 Nursing Nome 5 Residence 6 Other (Specify) FOUNDURY 27. MANNER OF DEATN 28a. DATE OF INJURY 28c. INJURY AT WORK? 28d. DESCRIBE NOW INJURY OCCURED Natural 5 Pending Investigation SUBJECT INGESTED METHADONE 11:00AM 1 YES 2XX NO FOUND: 11-24-95 ВУ 2 Accident 281. LOCATION (Street and Number of Rural Route Number City of Town, State) 9628 52ND AVE. 28s. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 3 Suicide a)() Could not be COMPLETED 4 Homicide FOUND: RESIDENCE COLLEGE PARK, MD. 29s. CERTIFIER

(Chack only 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(a) and manner as stated 2 💢 MEDICAL EXAMINER: On the besis of examination and/or investigation, in my opinion, death occured at the time, data and piece, and due to the cause(s) and manner as stated. 296. BIGNATURE AND TITLE OF CERTIFIER 29c LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE MALE AND ADDRESS OF PERSON WHO COMPLETED CHOSE OF DEATH (ITEM 27) (Type, Print) NOVEMBER 28, 1995 O.C.M.E. 2 111 Penn Street, Baltimore, Maryland 21201 HEUDORE

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death centres be executed within an opposed here of the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attention physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hyperme prior to burial, cremation, or removal.

IMPORTANT: If hem 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

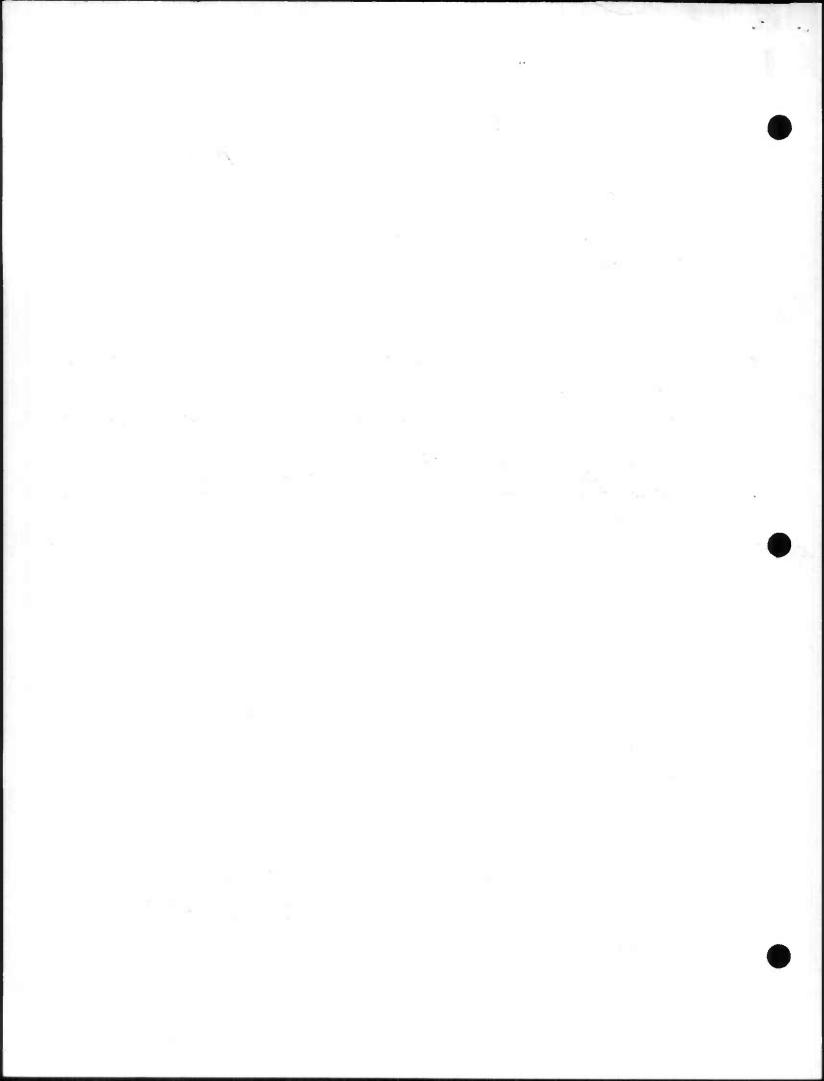
1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAR	C	ERTIFI	CATE	OF DEATH	REG. NO					
	1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH DAY YEAR MONTH DAY YEAR										
	LYNETTE M. BAH				DEC. 7	10:07 AMM					
		SEX 6. AGE (In yrs. les		IF UNDER 1 YE		7. DATE OF BIRTN (Month, Day, Year)	Coun				
	259-26-8460 ¹ 9a. FACILITY NAME (If not institution, give street	□ M XX 70	YRS.			DEC.17,		EORGIA			
OC			- 1		WN OR LOCATION OF D	EATN	9c. COUNTY OF				
6	RESIDENCE OF DECEDENT	14176 OLD WYE MILLS ROAD					TALBOT				
DIRECTOR	10a. STATE 10b. COUNTY		10c. CITY	TOWN OR LO	CATION			10d. INSIDE CITY			
	MARYLAND TALBO		WYE	MILLS			LIMITS?				
4	10e. STREET AND NUMBER				10f. ZIP CODE	WHAT COUNTRY?					
FUNERAL	14176 OLD WYE M	ILLS ROAD			21679 USA						
5	11. MARITAL STATUS 12 1 Never Merried 2 Merried	13, WAS	DECENDENT OF NISPA , specify Cuben, Mexico	or No- 14, RAC Blac	E — American Indian, ik, White, etc.						
BY	3 Widowed 4 Divorced	FORCES? 1 YES 2 THE		1 ☐ YES 2XXVIO Specify: Specify: WHITE							
1	15. DECEDENT'S EDUCATI	ON 16a, DE	CEDENT'S L	ISUAL OCCUP	ATION	16h KIND OF BU	SINESS/INDUSTRY	птть			
E	(Specify only highest grade corr Elementary/Secondary (0-12)	npleted) (Gi	ive kind of wi Do NOT use	ork done during	most of working	ios. iiiio oi oo	SINESS/INDUSTRY				
릴	8		FICE	MANA	GER	DE	NTAL				
COMPLETED	17. FATNER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname)										
BE (J. ALDRICH BRYA	ANT			ESM	A WELLS					
2	19a, INFORMANT'S NAME (Type/Print)				et and Number or Rural						
	EDWARD T. PERKIN										
	20a. METHOD OF DISPOSITION 1 Burlel 2 Cremation 3 Removal	from State cemetery, cre-	matory or oth	er place)	I (Name of		CATION — City or T				
	4 Donation 3 Other (Specify) SALISBURY CREMATORY 12-8 SALISBURY, MD										
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY NEWNAM FUNERAL HOME, P.A.										
	JOHN R.	JOHN R. MERCERON CEST 200 S. HARRISON ST., EASTON, MD									
	23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate										
- 1	IMMEDIATE CAUSE (Fins) Onset and Death										
	resulting in death) s. Yung Cauca 2418										
		DUE TO (DR AS A CONSEQUENCE OF):									
ON	Sequentially list conditions, b										
E I	DUE TO (OR AS A CONSEQUENCE OF):										
CERTIFICATION	CAUSE (Disease or injury that initiated events OUE TO (OR AS A CONSEQUENCE OF):										
	resulting in deeth) LAST										
	PART II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS										
EDICAL	Train at other eignmeets conditions of	Part I. 24s. WAS AN PERFOR		AWAILABLE PRIOR TO COMPLETION OF CAUSE							
	1 □ YES 2 W NO										
Σ	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN										
PHYSICIAN:	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES Y NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one)										
22	EXAMINER? HOSPITAL: OTHER:										
Ξ	27. MANNER OF DEATH	28e. DATE OF INJURY	28b. TIME		fome 5 Residence	6 U Other (Specify) 28d. DEŞCRIBE HOW INJURY OCCURED					
- 10	1 Netural 5 Pending	(Month, Day, Year)	INJU	RY	WORK? YES 2 NO						
BY	n Delete	28e. PLACE OF INJURY — At hor	me, farm, sti	reet, factory, c	ffice	281. LOCATION (Street and Number or Rural Route Number,					
E I	4 Nomicide determined										
COMPLET	29e. CERTIFIER (Check only PNYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated.										
N N	one) 2 MEDICAL EXAMINER: On the beals of examination end/or investigation, in my opinion, death occurred at the time, data end place, and due to the cause(s) and manner as stated.										
116	296. SIGNATURE AND TITLE OF CENTIFIED (Month, Day, Year)										
BE	Durd Hou	W			D358	77	D 12/7	195			
유	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)										
	DAVID H. SMITH, M.D., 509 IDLEWILD AVENUE, EASTON, MD 21601										
	31. DATE FILED (Month, Day, Year) 32. 9EOISTRAR'S SIGNATURE.										
1	DEC 07 1995	Julia Davidson Ra	dalle								

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		1 - STATE REGISTRAR		SIAIE UP I	MARTL		RTIF			DEA		MENIA	REG. NO.	E		
		1. DECEDENT'S NAME (First, Midde ALICE	fle, Last)	(30	RGI	nA,						MON	E OF DEATH DA	Y C	YEAR S	3. TIME OF DEATH 9150 M
1		4. SOCIAL SECURITY NUMBER		5. SEX	6. AGE	(In yrs. last		IF UNDE	DAYS	IF UNDE	R 24 HRS.	7. DATE OF BIRTH			a BIRTHEI ACE (Create or	
α		578 - 05 - 649	92	2	YRS.						8,9190			nsylvania		
	œ	9e. FACILITY NAME (If not institution		,						OR LOCAT	ION OF DE	EATH			JNTY OF DE	
	2	Laurel Regiona	AT H	ospital_				Lau	rel					Pr	ince	George
	띪	10e. STATE 10b. COUNTY					10c, CITY, TOWN OR LOCATION							10d. INSIDE CITY LIMITS?		
		Maryland H		La	urel	7							1 TES 2 NO			
	RAI	100. STREET AND NUMBER 10324 Winners Circle Way							1	2072				10g. CIT		HAT COUNTRY?
	NE I	11. MARITAL STATUS 12. WAS DECEDENT EVER IN				N U.S. ARA						IIC OBIG	IN? (Specify Yes			- American Indian,
	В	1 X Never Merried 2 Merried FORCES? 1 IF YES, GIVE WAR				2 XN	2 XNO If yes, specify Cuben, Mexican, Puerto Ricen, etc.) Black, W							White, etc.		
		15. DECEDEN (Specify only high				16a. DEC	CEDENT'S	USUAL I	OCCUPAT e during rr	ION nost of work	ina	16	6. KIND OF BUS	SINESS/IN	DUSTRY	
	9	Elementary/Secondary (0-12)		College (1-4 or 5	+}	life.	(Give kind of work done during most of working life. Do NOT use retired.)									
C. C.	MP	Grade 8 17. FATHER'S NAME (First, Middle.	1 1			Sa.	les	Mana	ger							Printer
at on		Francis S. Bo	,	n									Middle, Meiden beth Wal			
Hed	0	19e. INFORMANT'S NAME (Type/P				19b	MAILING	ADDRE	SS (Street				mber, City or Town		In Code)	
t CT	유	Viola Gleaton														nd 20723
st be		20g METHOD OF DISPOSITION 1 (文 Buriel 2 ☐ Cremetion 3	☐ Rem	oval from State		. PLACE A				Neme of		DA	TE 20c, LO	CATION -	- City or Tov	vn, State
T BE		4 Donetton 5 Other (Specify) Mt. Olivet Cemetery 12/6 Washington, D.C.											D.C.			
vent, the medical examiner		21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Donaldson Funeral Home, P.A.														
		313 Talbott Ave. Laurel, Maryland 20707														
		23. PART I. Enter the dieses	ses, or of fallura.	complications the	t ceuse use on a	d the dec	eth. Do	not ente	er the m	node of dy	/ing, suc	h ss ce	rdlec or respi	ratory e	rrest,	Approximats Interval Between
		IMMEDIATE CAUSE (Final disease or condition resulting in death)										Onset and Death				
ent,		resulting in death)		a	(OR AS	A CONSEC	DUENCE O	<u> </u>	(a)	1>	_					Dans
ic ev	_															
ешп	임	Sequantially list conditions, If arry, leading to immediate DUE TO (OR AS A CONSEQUENCE OF):														
PT TE	2	cause. Enter UNDERLYING CAUSE (Disease or Injury the leighted empts.														
r oth		that initiated eventa resulting in death) LAST														
	빙	0.											-			
y in	정	PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED?										WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE				
HOWS		1 U YES 2 NO.										OF DEATH?				
	Σ	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN											T YES 2 NO			
m 23	¥	25. WAS CASE REFERRED TO ME EXAMINER?					E OF DEA	TH (Chec	ck only on							
5 ≥	SIC	1 YES 2 NO		HOSPITAL:	ER/Out	patient 3	□ DOA	OTHE 4 IN		ome 5 🗆 F	tesidence	6 🗆 Oti	her (Specify)			
	F	27. MANNER OF DEATH 1 Natural 5 Pend	(Month, Day, Year)						V	NJURY AT VORK?		28d. D	28d. DEŞCRIBE HOW INJURY OCCURED			
шац	B	2 Accident inves	stigation	ition "" 1 TES 2 NO												
item 28 is PLETED	밀	3 Suicide 6 Could not be determined 28e. PLACE OF INJURY — At home, farm, street, fectory, office building, etc. (Specify) 28e. LOCATION (Street end Number or Plura City or Town, State)									er or Hural H	oute Number,				
		29e. CERTIFIER (Check only Ch														
	N N	(Check only one) 2 MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner es stated.														
RIAN		II 29h SIGNATURE AND TITLE OF CERTIFIED									(Month, Day, Year)					
IMPO	0	1 1-1- m 5 8 12-							12-	2-95						
	F	PRITAM SSAINFMA LAUREL MD 20708.														
		31. DATE FILED (Month, Day, Year)	400	32. REGISTR	AR'S SIGI	NATURE			0,000	-101		- /	, p	10	-	
RTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. E COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION TO BE COMPLETED	- 1	DEC 11 C	144	h Jales 0	Juna	LOCAL	Mall									



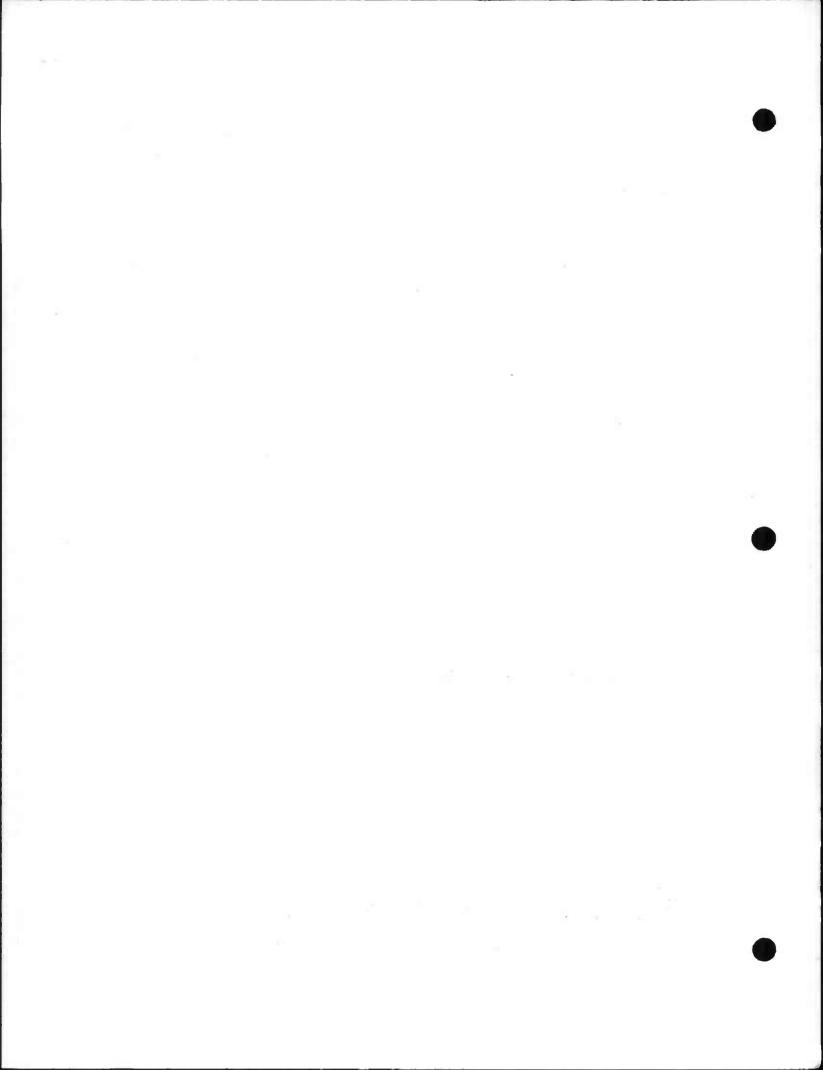
BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within the new parts of the death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	FOR 1 - STATE REGISTRAR	STATE OF MARYL	AND / DEPART	MENT OF H	EALTH AND	MENTA						
	1. DECEDENT'S NAME (First, Middle, Last)		DEATH	REG. NO. 2. DATE OF DEATH 3. TIME OF DEATH								
	Pauline	Bortz				MONTH DAY YEAR					Рм	
	4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE (IRS. 7. DATE OF BIRTH S. BIRTHPLACE (State of Form				
	313-24-0137 9e. FACILITY NAME (If not institution, give stre	1 M 2 XF 84	YRS.	Dec 25, 1910						Country) Illinois		
DIRECTOR	Mertdian Nursing I			Silve	%c. county of DEATH Montgomery							
EC	10e. STATE 10b. COUNTY		10c. CITY,	TOWN OR LOCAL	TON			10d, INSIDE CITY				
	Maryland Hov	ward	Cla	Clarksville					LIMITS? 1 YES 2 10g. CITIZEN OF WHAT COUNTRY			
FUNERAL		•		10								
J.	12933 Kentbury Dri	ILC ADMED	40.11110.055	21029		United S						
BY FL	1 Never Merried 2 Merried 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR DA	2 200	ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify If yes, specify Cuben, Mexicen, Puerto Ricen, etc. 1 YES 2 NO Specify:						- American Indi White, etc. y: White		
	15. OECEDENT'S EDUCA	TION	15a DECEDENT'S II	DECEDENT'S USUAL OCCUPATION 16b, KIND OF BUSINESS/INDUSTRY								
	(Specify only highest grade of Elementery/Secondary (0-12)	(Give kind of wo	ork done during mo retired.)	100	A KIND OF BU							
립	unknown	Homema	ker			Own	Home					
COMPLETED	17. FATHER'S NAME (First, Middle, Last)	TACATICATICA	101	18, MOTHER'S NA	AME (First.							
BE C	Max Dunn				Sonia	Sko		,				
	19a. INFORMANT'S NAME (Type/Print)		19b. MAILING	ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)								
유	Mrs. Dionne Frank				ry Drive					and 210	29	
	20e. METHOD OF DISPOSITION		PLACE AND DATE OF	DISPOSITION (Na		DAT		CATION - CIT	_			
	1 Burlel 2 Removal from State 4 Donetton 5 Other (Specify) Balt-Washington Crematory 12-5 Laurel, Maryland											
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY											
	> Shima	Harry H Witzke Funeral Home, Inc.										
	23. PART i. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, Approximets											
	snock, or heart failure. List only one cause on each line.										atween	
	IMMEDIATE CAUSE (Finel disease or condition resulting in deeth)									Onset and		
	resulting in deeth) Due TO (OR AS A CONSEQUENCE OF):										حريب	
Z												
원	Sequentielly list conditions, If any, leading to immadiate DUE TO (OR AS A CONSEDUENCE OF):											
CERTIFICATION	CAUSE (Disease or injury											
E	that initiated events DUE TO (OR AS A CONSEDUENCE OF): resulting in deeth) LAST											
H	d											
AL C	PART II. Other significent conditions contributing to deeth but not resulting in the underlying ceuse given in Part i. 24a. WAS AN AUTOPSY 24b. WE										INDINGS	
C	Myelodys		PERFOR			WAILABLE PRIOR TO COMPLETION OF CAUSE						
MEDIC							1 - YES 2 - NO		OF DEATH?			
2	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO LUNCERTAIN								1 YES 2	NO		
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one)											
Sic	EXAMINER? 1 VES 2 NO 1 Inpatient 2 ER/Outpatient 3 DOA 4 Muraing Home 5 Realdence 6 Other (Specify)											
Ě	27. MANNEB OF DEATH	26e. DATE OF INJURY (Month, Day, Year)	28b. TIME	DF 28c. INJ	28c. INJURY AT 28d. DESCRIBE HOW INJURY OCCURED							
βÁ	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Idai)	INJO	M 1 YES 2 NO								
	3 Sulcide S Could not be	28a. PLACE OF INJURY - building, etc. (Specia	At home, farm, str	eet, factory, office		281. LOCATION (Street and Number or Rural Route Number, City or Treen, State)						
	4 Homicide determined City or Town, State)											
COMPLETED	29e. CERTIFIER 1 CERTIFYING PHYSICIA	AN: To the beat of my knowle	edge, death occurred	at the time, date	end place, end due	to the cas	use(e) end men	iner ee atated.				
8	296. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) end menner ee stated. 2 MEDICAL EXAMINER: On the best of examination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) and menner ee stated.											
	296. SIGNATURE AND TITLE OF CENTIFIER 29d. DATE SIGNED (Month Dev Year)			
BE (Jolley Horn	whis	>		Describer 4 1995							
유	30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print).										-	
	ROBERTH. KNITZERM. D. 1814 Prince Philip Ditt312 OLNEY, MD ZOBZ											
	DEC 0 7 1995 Jalia davalur Randell											



9c. COUNTY OF DEATH

Howard

3. TIME OF OEATH

3:45

10d. INSIDE CITY

1 YES 2 NO

8. BIRTHPLACE (State or Foreign

926 South Carolina

10g. CITIZEN OF WHAT COUNTRY?

Specify

United States

14. RACE -- American Indian Black, White, etc.

White

Approximate

24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE

OF DEATH? 1 YES 2 NO

29d. DATE SIGNED (Month, Day, Year)

December

124356

Interval Batween

Onset and Death

P

REG. NO

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

2

31. DATE FILED (Month, Day, Year)

1995

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FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

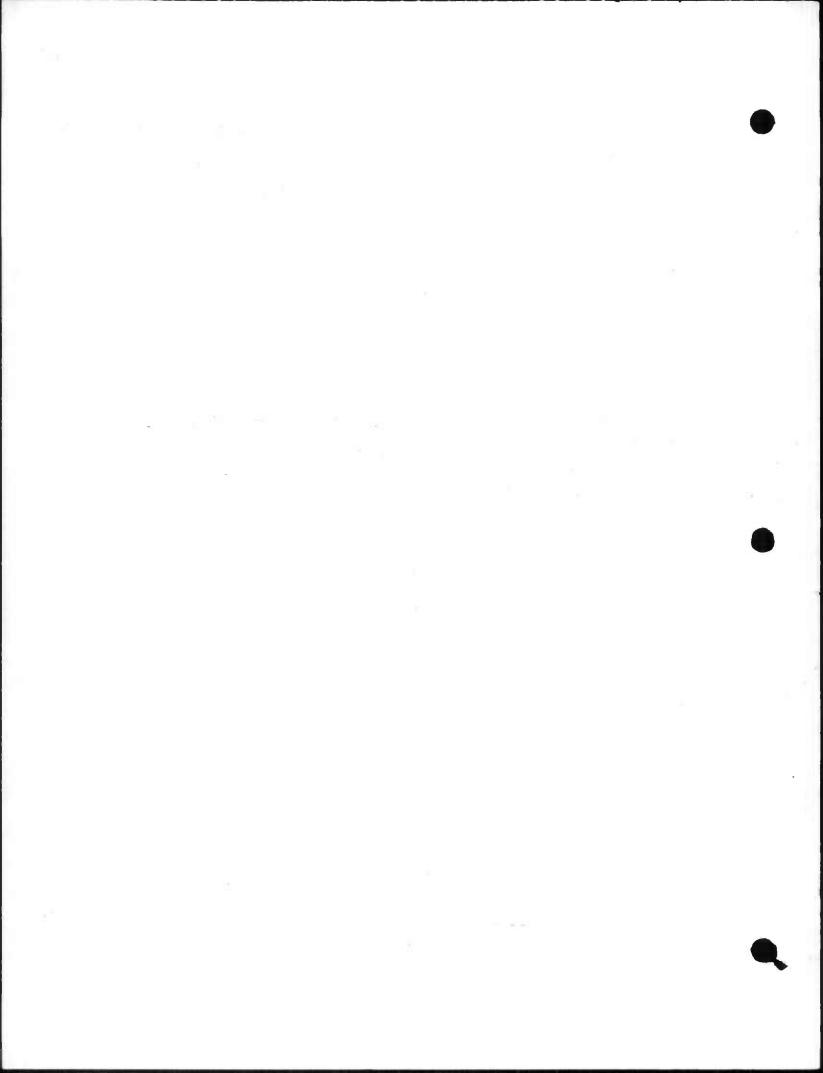
2. DATE OF OEATH MONTH Rebecca J. Britt December 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. lest birthday) 5. SEX IF UNDER 1 YEAR IF UNDER 24 HRS 7. DATE OF BIRTH (Month, Day, Year DAYS HOURS 1 M 2 F YRS 247-32-7447 March 25, Pages 1, 2, 3 should 9e. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF GEATH DIRECTOR 2717 Brinkleigh Drive Ellicott City RESIDENCE OF DECEDENT 10a STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION Maryland Howard Ellicott City permit. FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE use as the burial-transit 2717 Brinkleigh Drive 21042 after death. Page 6 may be retained by the hospital or attending physician. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or NoIf yes, specify Cuben, Mexican, Puerto Rican, etc.)
 U YES 2 (X NO Specify: BALTIMORE, MARYLAND 21215-0020 FORCES? 1 YES 2
IF YES, GIVE WAR OR DATES 2 NO 1 Never Married 2 Married BY 3 Widowed 4 Divorced ETED. 15. DECEDENT'S EDUCATION 16a, DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for Health and Mental Hygiene prior to burial, cremation, or removal. Elementary/Secondary (0-12) College (1-4 or 5+) COMPL 4 Teacher Education 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Surname) be notified at Robert Henry Bertha Jacques Mae 8 Cooper 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Ray H. Britt 2717 Brinkleigh Drive Ellicott City, MD 21042 20e, METHOD OF DISPOSITION 20c. LOCATION - City or Town, State 20b. PLACE AND DATE OF DISPOSITION (Name of OATE must 1X Buriet 2 Cremetion 3 Removal from State 4 Donation 5 Other (Specify) 12-9 Crest Lawn Cemetery Marriottsville, MD examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Harry H. Witzke Funeral Home, Inc. a. 4112 Old Columbia Pike Ellicott City 21043 medicai 23. PART i. Enter the diseases, or complications that caused the deeth. Do not enter tha mode of dying, such as cerdiac or reapiratory arrest, ehock, or heart fellure. Liet only one cause on each line. IMMEDIATE CAUSE (Final the disease or condition resulting in death) rosulmona event. Mitartan other traumatic CERTIFICATION Sequentially list conditions, TO (OR AS A CONSEQUENCE OF) If any, leading to immediate cause. Enter UNDERLYING Coneces CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF) that initiated events resulting in death) LAST any injury, PART ii. Other significant conditions contributing to deeth but not resulting in the underlying ceuse given in Part I. 24s. WAS AN AUTOPSY PERFORMEO? MEDICAL 1 TYES 2 this certificate has been with the State Dept. of DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO I PHYSICIAN: UNCERTAIN OR ATTENDING PHYSICIAN: The law 23 25. WAS CASE REFERRED TO MEDICAL 26, PLACE OF DEATH (Check only one) item **EXAMINER?** HOSPITAL: OTHER: 1 YES 2 NO 1 Inpetient 2 ER/Outpetient 3 DOA Residence 8 Other (Specify) 6 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d. OESCRIBE HOW INJURY OCCURED marked. 1 Natural 1 YES 2 NO DIRECTOR: After the hours after death v ВҰ Accident Investigation 28e. PLACE OF INJURY — At home, term, street, fectory, office building, stc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 28 is Could not be datarmined COMPLETED 4 Homicide TO THE HOSPITAL OR ATT TO THE FUNERAL DIRECT be filed within 72 hours a IMPORTANT; If Itom 2 29a. CERTIFIER CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated. MEDICAL EXAMINER: OF end/or investigation, in my opinion, death occured at the time, date end place, and due to the cause(s) and manner as stated. 29b. SIGNATURE TITLE OF CERTIFIER 29c. LICENSE NUMBER BE

CAUSE OF DEATH (ITEM 27) (Type, Print)

32. REGISTRAR'S SIGNATURE

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

DHMH-18 Rev 1/89



OHMH-16 Rev 1/89

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TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should
be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	FOR STATE REGISTRAR	STATE OF MARYLA		NT OF HEALTH AND	MENTAL HYGIENI REG. NO.	1						
,	1. DECEDENT'S NAME (First, Middle, Lest) Dorothy	S.	Bogley		2. DATE OF OEATH DAY DECEMber 1	5.1995	3:10 AM					
	4. SOCIAL SECURITY NUMBER 217-36-9264	1 □ M 2 X F 86	YRS. MONT		MAY 19, 190	9 M/	THPLACE (Smite or Foreign ARYLAND					
TOR	FREDERICK MEMOR		96. 0	FREDERICK	EATH	FREDI	ERICK					
DIRECTOR	10a. STATE 10b. COUNT	ERICK		OERICK		10d. INSIDE CITY LIMITS? 1 YES 2 NO						
ERAL	100. STREET AND NUMBER 8035 BROKEN REED	COURT		101. ZIP CODE 21701			STATES					
BY FUN	11. MARITAL STATUS 1 Never Married 2 Married 3 Wildowed 4 Divorced	12. WAS DECEDENT EVER IN FORCES? 1 YES	2 NO	13. WAS DECENOENT OF HISPA If yes, specify Cuban, Maxic 1 YES 2 NO Speci	an, Puerto Rican, stc.)	Bla	CE — American Indian, lock, White, etc.					
LETED	16, DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12)		life. Do NOT use retire	one during most of working ad.)	16b. KIND OF BUS							
COMPL	9 17. FATHER'S NAME (First, Middle, Last)	0	HOMEMAKEF	18. MOTHER'S N	OWN H	Surname)	- 32					
TO BE	CHARLES SMALL MARY STANG 198. INFORMANT'S NAME (Type/Print) 198. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)											
-	JUDITH B. RANKIN 8035 BROKEN REED COURT, FREDERICK, MD. 21701 METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of Commence) 15 Burles 2 Cremetton 3 Removal from State Commence of C											
	4 Donation 5 Other (Specify)	ICENSEE O	ARNESTOWN "	EMETERY 1 22 NAME AND ADDRESS OF BA			N,MARYLAND					
	23. PART I. Enter the diseases, or	H. Bark		P.O. BOX 503	8 LAYTONSV	ILLE, M	ARYLAND					
		s. Breast Cu	ich line.				Approximate Interval Between Onset and Death					
TION	Sequentially list conditions, if sny, leading to immediate		- Sarcoma									
CERTIFICATION	csuse. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST	CDUE TO (OR AS A	CONSEQUENCE OF):									
4	PART II. Other significent condition	ns contributing to deeth b	ut not resulting in the	e underlying ceuse given in	n Part I. 24s. WAS AN PERFOR		4b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO					
: MEDIC	DID TOBACCO USE CONT	TRIBUTE TO CAUSE O	F DEATH YES [□ NO □ UNCERTA	1 Q YES 2	NO	OF DEATH? 1 YES 2 NO					
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO		26. PLACE OF DEATH (CH	neck only one) HER:		1						
	27. MANNER OF OEATH 1 Natural 5 Pending	28e. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	Nursing Home 5 Residence 28c. INJURY AT WORK? 1 YES 2 NO	28d. DESCRIBE HOW I	NJURY OCCURED						
ETED BY	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	26e, PLACE OF INJURY	— At home, farm, atreet,		281. LOCATION (Street a City or Town, State)	reet and Number or Rural Route Number, tate)						
COMPLE	Check only	SICIAN: To the best of my know					e(s) and manner as stated.					
BE	29b. SIGNAPORE AND TITLE OF CERTIFIE	Post		29c, LICENSE NUMBER 29d, DATE SIGNÉD (Month, Ohy, Year)								
TO	30. NAME AND ADDRESS OF PERSON W	HO COMPLETED CAUSE OF DE	TAY 18	400 Ridger	ll Blvd K	H Siry	4021771					
	31. DATE FILED (Month, Day, 266) DEC 2 0 1995	32 REGISTRAR'S SIGN	ATURE CRANCELL	0								

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TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed wittin 24 hours after death. Page 6 may be retained by the hospita	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached the study with the Crean Dear of Hastit, and Market should be interested from the property of the page 5 should be detached to the page 5.	the med within 12 index are death with the Coale dept. Or regard and injury, or other traumatic event, the medical examiner must be notified at once.
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9	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the face and interest the principle of the state interests the principle of the state of the s	M
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30. NAME AND ADDRESS OF PERS

SOLUTION

31. DATE FILED (Month, Day, Year)

DEC - 41

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	1 - STATE REGISTRAR	STATE OF MARYLAND /	DEPAR	TICATE OF	EALTH AND DEATH	MENTAL HYGIEN REG. NO						
	t. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH			3. TIME OF DEATH			
	Shirley L	ee Cress				Nov. 25 19		YEAR	7:05 AM M			
		5. SEX 6. AGE (In yrs. las	t birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH	7,7,5	6. BIRTH	IPLACE (State or Foreign			
	214 20 8779	1 □ M 2 □ F 69	YRS.	MONTHS DAYS	HOURS MIH.	(Month, Day, Year)	125	Count	ry)			
	9a. FACILITY NAME (If not institution, give street	AA J O		ah CITY TOWN C	R LOCATION OF D	Dec. 12,19	9c, COU		nsylvania			
œ						EATH	CENT HERE					
ē	9315 Sam Owings P1	wings Place Owings Calv										
DIRECTOR	10a. STATE 10b. COUNTY		10c. CI1	Y. TOWN OR LOCAT	ION				10d. INSIDE CITY			
E	Marria Calara		_	•					LIMITS?			
	Maryland Calver	T .] UV	rings	ZIP CODE		I 0171	751.051	1 YES 2 NO			
FUNERAL							10g. CI11	ZEN OF	WHAT COUNTRY?			
Ē	9315 Sam Owings Pl				0736			ted	States			
5		12. WAS DECEDENT EVER IN U.S. AR FORCES? 1 YES 2 X N	MED			NIC ORIGIN? (Specify Yearn, Puerto Rican, etc.)	or No-	14. RACI	E — American Indian, k, White, etc.			
ВУ	1 Never Married 2 Married 3 🖫 Widowed 4 Divorced	IF YES, GIVE WAR OR DATES	Io.		2 № NO Specif			Spec	#y: 571- 1 -			
				1					White			
E	15. DECEDENT'S EDUCA' (Specify only highest grade co	impleted) (G	ive kind of	Work done during mo		16b. KIND OF BU	SINESS/IND	USTRY				
Ш		College (1-4 or 5 +)	Do NOT u									
COMPLETED	11	Sec	reta	ry		U.S.D.A	١.					
Ö	17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NA	ME (First, Middle, Maiden	Surname)					
BE (Harold Christman				Rache	1 Detwiler						
	19a. INFORMANT'S NAME (Type/Print)	19	b. MAILING	ADDRESS (Street a	nd Number or Rural	Route Number, City or Tow	n, State, Zip	Code)				
5	Carolyn Thompson		9315	Sam Owi	ngs Plac	e Owings M	lary1	and	20736			
	20a, METHOD OF DISPOSITION	20b. PLACE	AND OATE	OF DISPOSITION (Ne			CATION -		own, Steta			
	t X-Surial 2 Cremation 3 Remove 4 Donation 5 Other (Specify)	el from State cemetery, cre	metory or o	Memorial	Cardona	11/29/95	Dozzi	daan				
	21. SIGNATURE OF FUNERAL SERVICE LICE	ISEE C	One	22. NAME AF	D ADORESS OF FA	CILITY	DayI	ISOH	VIIIE Ma.			
	Dalant 63	6,121010	2	Rober	t E. Eva	ns Funeral	Home	e, P	.A.			
	1000 C.	· COUNT,	1/19	<u>L 16000</u>	Annapol	is Rd. Bow	rie Mo	1. 2	0715			
	23. PART I. Enter the diseases, or co	mplications that caused the de et only one cause on each line	eth. Do	not enter the mo	de of dying, suc	h sa cardiac or reap	iratory arr	reat,	Approximata intervel Between			
	IMMEDIATE CAUSE (Fine) Onset and Death											
	disease or condition resulting in death)	1es bil	rak	w.fo	-leura	100			multe			
	DUE TO (OR AS A CONSEQUENCE/OF): /											
z	- wethotrexato and/or rhoumatried on the &											
0	Sequentially list conditions, if any, leading to immediate	DUE TO (OR AS A CONSE	OUENCE C	IF):								
EA!	cause. Enter UNDERLYING	DUE TO (OR AS A CONSE	mo	none c	undli	car our.						
Ě	CAUSE (Disease or Injury that initiated events	DUE TO (OR AS A CONSE	OUENCE C	F):	7							
CERTIFICATION	resulting in deeth) LAST	CTONO	401	and O	KLOW!	1-deser	1dex	al				
CE				57	1300	Cogse	10.0	-1	`			
4	PART II. Other aignificent conditions	contributing to death but not i	resulting	in the underlying	g ceuse given in	Part i. 24a. WAS AN PERFOI		240	. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO			
MEDICAL	- history of	myo cardial	ux	2 repor		1 🗆 YES :			COMPLETION OF CAUSE			
	ausonton	Cina			· ·				OF DEATH?			
2	DID TOBACCO USE CONTRI	BUTE TO CAUSE OF DEA	TH Y	ES [] NO [UNCERTAI	NA			t lites 2 lino			
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL			TH (Check only one)	OTTELKIA	العرا						
2	EXAMINER?	HOSPITAL:		OTHER:	~							
ΥS		I inpatient 2 ER/Outpetient 3		4 Nursing Hom		6 Other (Specify)						
F	27. MANNER OF DEATH 1 Natural 5 Pending	26a. DATE OF INJURY (Month, Day, Year)	28b. TII	JURY WO	RK7	28d. DESCRIBE HOW	NJURY OC	CURED				
ВУ	2 Accident Investigation				rES 2 NO							
	3 Suicide 6 Could not be	28e. PLACE OF INJURY — At he building, atc. (Specify)	ome, ferm,	street, fectory, offic		281. LOCATION (Street City or Town, State)		or Rural	Route Number,			
	4 Homicide determined				· · · · · · · ·							
PLI	29a. CERTIFIER 1 CERTIFYING PHYSICI	AN: To the best of my knowledge, de	eath occur	red at the time, date	and place, and du	to the cause(s) and ma	nner as stat	ted.				
COMPLETED	one)	On the basis of examination and/or	Investigati	on, in my opinion, d	eath occured at the	time, data and place, ar	nd due to th	te cause(s) and manner as stated.			
	29b. SIGNATURE AND TITLE OF CERTIFIER	, 111			29c. LICENSE NU	MRFD	20d DAT	E SIGNE	D (Month, Day, Year)			
BE	Marti	11-4				525	D. DAI	26	10 C			
2	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED ON USE OF DEATH HITE	*******	6.0	15-51	7 < <	1	4/4/	73			

PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

Tan Down 120 / To ght fall Road,

Wear)

32. REGISTRAD'S SIGNATURE

which was to the second of the

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

BALTIMORE, MARYLAND 21215-0020	ter death. Page 6 may be retained by the hospital or attending physician.	the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should boal.	al examiner must be notified at once.	TO BE COMPLETED BY FUNERAL DIRECTOR
DIVISION OF VITAL RECORDS, P.O. BOX 68/60	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

	1 - FOR STATE OF MARYLAN	D / DEPARTM CERTIFICA	ENT OF H	EALTH AND DEATH	MENTAL HYGIEN	E						
	1. DECEDENT'S NAME (First, Mickile, Last) Susan Adams Breedlove	Со	nner		2. DATE OF DEATH DATE 12/3/95	Y	YEAR 3	TIME OF DEATH	P			
	578.66.3472 1□M2 ▼ 47	7 YRS. MON		IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTN (Morth, Day, Year) April 13,	1948	Country)	ACE (State or For	niger			
TOR	9a. FACILITY NAME (If not institution, give atreet and number) 4110 Sycamore Street RESIDENCE OF DECEDENT	Chase	EATN	Mont								
DIRECTOR	Maryland Montgomery	10c. CITY, TO					Od. INSIDE CITY LIMITS? YES 2 X 1	10				
FUNERAL	4110 Sycamore Street	IOI. ZIF CODE						AT COUNTRY?				
COMPLETED BY FU	11. MARITAL STATUS 1 Never Married 2 Married 3 Wildowed 4XX Divorced 12. WAS DECEDENT EVER IN U.S FORCES? 1 YES 2 IF YES, GIVE WAR OR DATES	₹ NO	If yes, spe	NDENT OF NISPAI city Cuben, Maxica 2 XNO Specif	NIC ORIGIN? (Specify Yea in, Puarto Rican, atc.) y:	or No 1	Black, Y	American Indian White, atc. White	1,			
	15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5 +) 4	Give kind of work of life. Do NOT use reti	fone during mos	N t of working	166. KIND OF BUS	iness/indus		<u> </u>				
BE CON	17. FATNER'S NAME (First, Middle, Last) Joseph P. Breedlove	Doro	ME (First, Middle, Maiden s thy Pat	Sumame)								
2	Jos. P. Breedlove	4110 S	ycamo	re Str	Route Number, City or Town eet, Chev	y Ch	ase		208			
	20e. METHOD OF DISPOSITION TYPE Burles 2 Segmention 3 Removal from State Commetter Commetter Removal from State											
	5130 WI AVE NW WASHINGTON DC 20016											
CERTIFICATION	IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially liet conditions, if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury	FATLURE NSEQUENCE OF): HE TONGUE NSEQUENCE OF):	<u> </u>	a or dying, suc	n as certilac of reaph	atory arres	it,	Approximatinterval Bet Onset and 2 DAYS 1 YEAR	lween Death			
AL CERTII	resulting in death) LAST	that initiated events DUE TO (OR AS A CONSEQUENCE OF): d										
PHYSICIAN: MEDIC	DID TOBACCO USE CONTRIBUTE TO CAUSE OF D	EATH YES [□ No X	UNCERTAIN	PERFORI		OI	AVAILABLE PRIOR TO COMPLETION OF CAUSE OF OEATH? 1 YES 2 NO				
SICIA	25. WAS CASE REFERRED TO MEDICAL 28. P	CT	UEO:	XX northern	6 Other (Specify)							
ВУ РНУ	27. MANNER OF DEATN 1 Netural 5 Pending 2 Accident Investigation	26b. TIME OF INJURY	28c. INJU WOR 1 Y	RY AT	26d. DESCRIBE HOW IN	JURY OCCU	RED					
	3 Suicide 6 Could not be 4 Nomicide determined 28e. PLACE OF INJURY — A building, etc. (Specify)	t home, larm, street,	factory, office		281. LOCATION (Street a: City or Town, State)	nd Number or	Rural Rout	te Number,				
COMPLETED	(Check only one) 2 MEDICAL EXAMINER: On the beat of axamination and							nd manner as sta	ted.			
TO BE												
	Kevin Cullen, M.D. 3800 Resev	oir Rd. 1		shingto	n D.C. 20	007						
	DEC 07 1995 July Devoter &	erdall						DHMH-16	Rev 1/6			

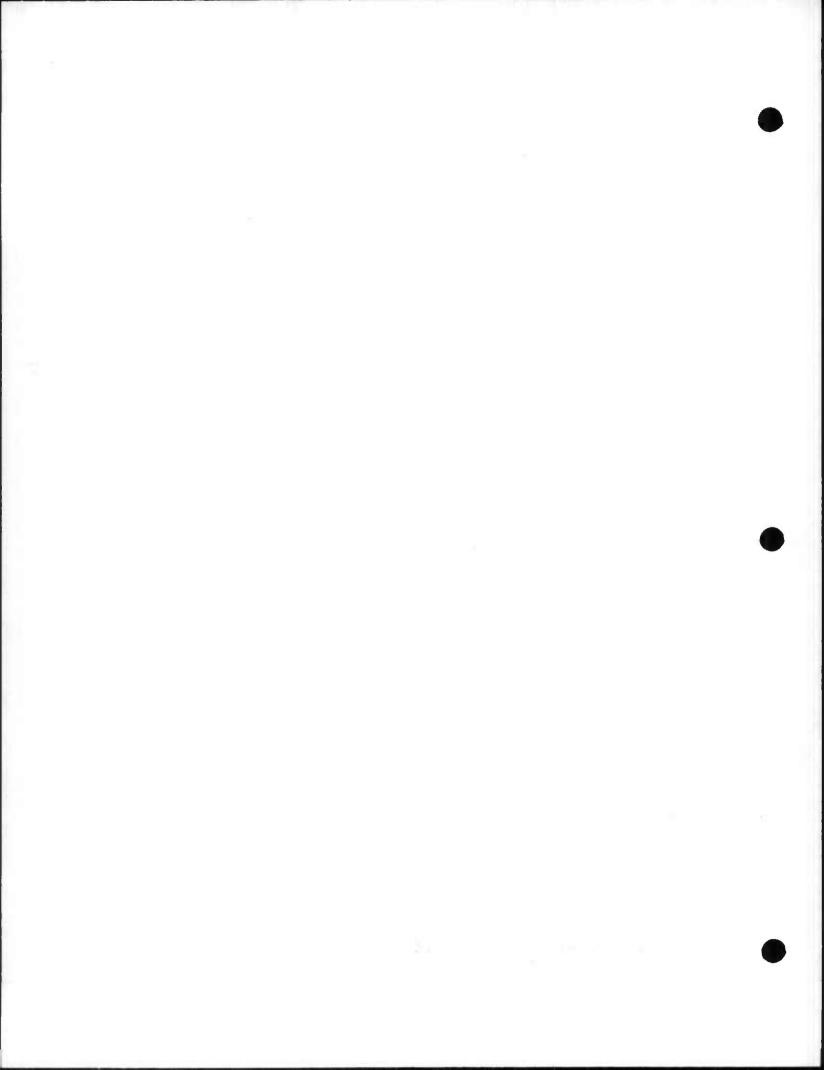
alternative of the first

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the buriat-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to buriat, cremation, or removal.	IMPORTANT: If item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	TO BE COMBI EYEN BY BUYCLOLAM, MENION OF PRINCIPLE
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FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. 1 -REG. NO.

	1. DECEDENT'S NAME (First, Middle, Last)	D - 4			_			1	2. DATE OF D	EATH DA	Y	YEAR	3. TIME OF DEATH
		Barto	J. C1	rivel	la			I	Decemb	er	6 1	995	1:15 A M
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. les	birthday)	IF UNDER 1 YE		JNDER 24 H	W. C.	7. DATE OF B (Month, Day	IRTH		a. BIRTH Countr	PLACE (State or Foreign
	578-38-5170	1 X M 2 □ F	82	YRS.	MONTHS DA	WB HOL	JRS MI		ec. 16		912	Penr	nsylvania
	9a. FACILITY NAME (If not institution, give	street and number)			9b. CITY, TO	WN OR LO	CATION C			,		NTY OF D	
OR	8109 Kerry Road			- 1	Ch	evy (Chas	e			Me	nto	omerv
DIRECTOR	RESIDENCE OF DECEDENT										JII C G	onici y	
3				10c. CITY	, TOWN OR L								10d. INSIDE CITY LIMITS?
Δ	MD 100. STREET AND NUMBER	Montgome	ry	<u> </u>	Ch	evy (e					1 X YES 2 NO
RA						10f. ZIP	CODE				10g. CIT	IZEN OF V	VHAT COUNTRY?
W	8109 Kerry Road						-	208				. S.	Α.
5	11. MARITAL STATUS 1 Never Married 2 Married		T EVER IN U.S. AR						ORIGIN? (Sp Puerto Rican		or No-	14. RACE	— American Indien, c, White, atc.
BY FUNERAL	3 Widowed 4 Divorced	IF YES, GIVE Y	WAR OR OATES			YES 2 K						Speci	White
	15. DECEOENT'S EDU	ICATION	16a, DE	CEDENT'S	USUAL OCCU	PATION			16h KINI	OF BUILD	INESS/INC	MIRTON	wiitre
H	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4 or 5	(Gi	ve kind of w Do NOT use	ork done durin retired.)	g most of v	working		100. 1014	OF 803	meas/mc	7031R1	
립	8	College (1-4 Or 5		Esta	ate Br	oker			Rea	1 Es	tate		
COMPLETED	17. FATHER'S NAME (First, Middle, Last)					_		S NAME	(First, Middle				
BE C	James Vincent	Crivel1a	a			L	ucv	D'	Amore				
	19e. INFORMANT'S NAME (Type/Print)		196	MAILING	AODRESS (St					lty or Town	, State, Zip	Code)	
9	Vincent L. Cr	ivella	91	13 Ch	nerbou	rg D	rive	P	otoma	c. M	D 2	0854	
	20e. METHOD OF DISPOSITION 1 Derial 2 Cremation 3 Rem	and to a State	20b. PLACE A	NO DATEO	F DISPOSITIO				DATE		ATION —		wn, Stata
- 1	4 Donation 5 10 Other (Specify) En	tombment	Fort	netory or oth Linco	In Ce	meter	rv		12/9	Brei	ntwo	bo	Maryland
	21. SIGNATURE OF FUNERAL SERVICE LI	CENSEE /	,		22, NAM	E AND AD	DRESS O	F FACIL	Jose	ph (Gaw1e	r's	Sons
	1 0 1 1 01	1			5130	WI.	Ave.	N.	W. Wa	shin	gton	, DC	20016
	23. PART V. Enter the diseases, or	complications the	t coused the dea	ith. Do n							_		
	anock, or neart reliure.	Liat only one ceu	ee on eech iine.				- cynng,		a cardiac (or reepii	atory arr	eat,	Approximata intervai Between
	iMMEDIATE CAUSE (Final disease or condition	CARDIA	C ARREST										Onset and Death
ŀ	resulting in death)	4	(OR AS A CONSEO):								HIN
z		CORONA	RY ARTER	TERY DISEASE 10 YE								10 YEARS	
은	Sequentielly list conditions, If any, landing to immediate	DUE TO	(OR AS A CONSEO	UENCE OF);								20 IIMINO
S	cause. Enter UNDERLYING CAUSE (Disease or injury	c. ANEMI	A										1 YEAR
E	that initiated events		OR AS A CONSEO		:								
MEDICAL CERTIFICATION	reaulting in death) LAST	d	K DLADDE	K									5 YEARS
2	PART ii. Other aignificant condition	e contributing to	death but not re	eulting Ir	the under	vina cau	ee civer	in De	et l 24c	WAS AN A	LITTORON	0.05	WERE AUTOPSY FINDINGS
S	ARTRIAL FIBRILL				· · · · · · · · · · · · · · · · · · ·	ying out	ao givai		240.	PERFORM		240.	AVAILABLE PRIOR TO COMPLETION OF CAUSE
	WEIGHT LOSS	ALION							_ 10	YES 2	NO NO		DF DEATH?
		DIDLITE TO CA	UCE OF DEAT	FIL ME		—			777				1 TES 2 NO
A	DID TOBACCO USE CONT. 25. WAS CASE REFERRED TO MEDICAL	RIBUTE TO CA			(Check only		NCERI	AIN	P.				
PHYSICIAN	EXAMINER? 1 YES 2 NO	HOSPITAL:			OTHER:								
¥	27. MANNER OF DEATH	1 Inpatient 2 I		28b. TIME	4 Nursing	Home 5.2		_	Other (Spe 8d. OESCRIB	,,	IIIBY OO	MIDED	
	1 X Natural 5 Pending	(Month, D		INJU	RY	WORK?			ou. OESCHIB	E HOW IN	JUNY OCC	UNED	
BY	2 Accident Investigation 3 Suicide 6 Could not be	28e. PLACE O	F INJURY — At hon	ne, farm, at					61. LOCATION	(Street ac	nd Number	or Rural A	outs Number
	4 Homicide datarmined	building,	atc. (Specify)						City or Tow	n, State)	T TTOTAL	01 11010111	outo riumbus,
COMPLETED	29a. CERTIFIER 1 TO CERTIFYING PHYSI	CIAN: To the heat of	en benededes des									-	
P I	(Check only one) 1 CERTIFYING PHYSI (Check only one) 2 MEOICAL EXAMINE												
	29b. SIGNATURE AND TITLE OF CERTIFIES				, its my opinio					Place, and			
BE	audin A	mille	Inita.	. 1	20	- 1	LICENSE		ER				(Month, Day, Year)
2	30. NAME AND ADDRESS OF PERSON WH	O COMPLETED CALL	E CE DELL'E	7 /6			309	/			P /	1-6	- 95
	Saulius Naujokai						3.7		TT1			D -	20016
	31. DATE FILED (Month, Day, Year)		R'S SIGNATURE	wew.	mex1co	AVe	. N.	W	wash	ingt	on,	ש, (20016
الـــــــــــــــــــــــــــــــــــــ	DEC 07 1995	Jalia de	voler Real	11									





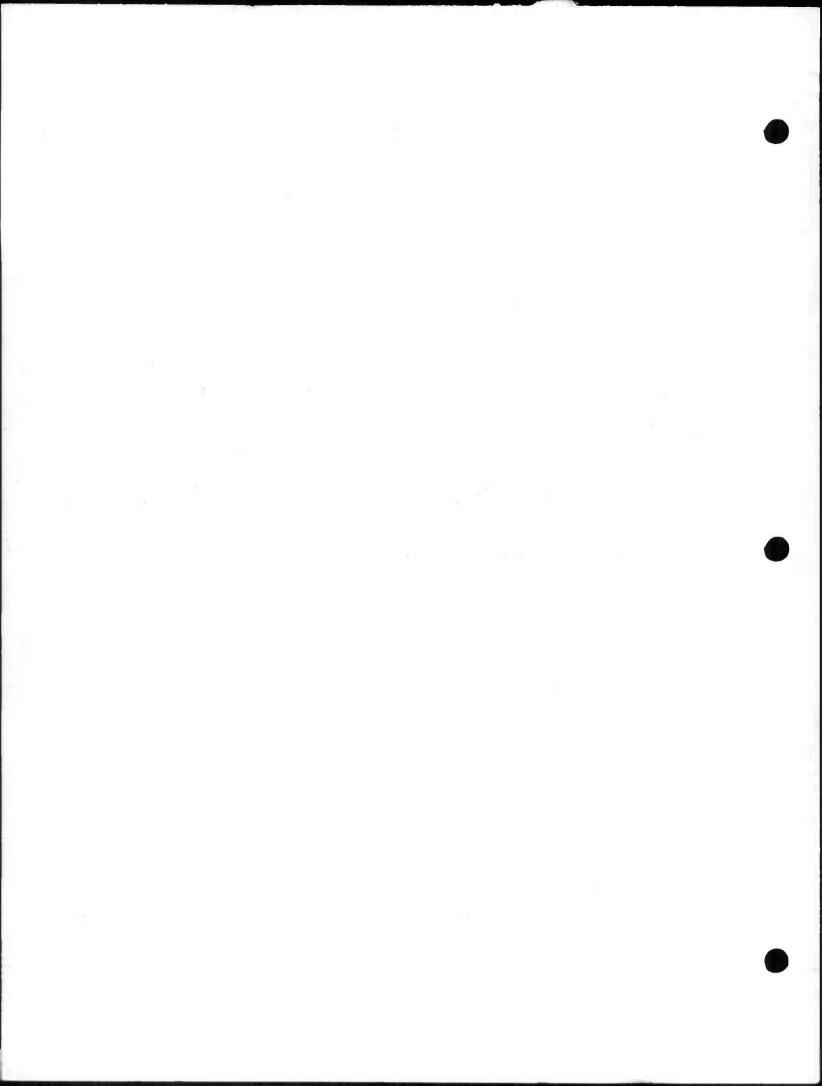
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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

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IMPORTANT: If them 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	REGISTRAR		CERTIF	ICATE C	F DEATH	Н	REG	3. NO.			
	1. DECEDENT'S NAME (First, Middle, Last)						DATE OF OEA	DAY	VEAR	3. TIME OF DEATH	
	Wi	lliam Howard	d Calfee			cembe	ber 2, 1995 7:32 P				
	4. SOCIAL SECURITY NUMBER		(In yrs. lest birthday)	IF UNDER 1 YE	AR IF UNDER 24	\rightarrow	DATE OF BIRT			HPLACE (State or Foreign	
	579-12-3228		86 YRS.	MONTHS DA		Man (Month, Day Y	(har)	Count	try)	
			00 1113.				eb. 7,	1909		nington, DC	
	9a. FACILITY NAME (If not Institution, give s		7//	VN OR LOCATION			9c. CO	UNTY OF	DEATN		
8	7206 45th Street	t		Chev	y Chase	9		Mo	ntgon	nery	
5	RESIDENCE OF DECEDENT										
DIRECTOR	10a. STATE 10b. COUNT	Υ	10c. CIT	Y, TOWN OR L	CATION					10d. INSIDE CITY LIMITS?	
	Maryland Monto	gomery	Che	vy Cha	se					1X YES 2 NO	
A	10e. STREET AND NUMBER				10f. ZIP CODE			10g. C	ITIZEN OF	WHAT COUNTRY?	
FUNERAL	7206 45th Stree	et:			20815	,			Unite	ed States	
Ž	11. MARITAL STATUS	12. WAS DECEDENT EVER	N II S ARMED	12 WAS	DECENDENT OF		DIGIN2 (Spec				
	1 Never Married 2 Married	FORCES? 1 YES	2 X NO	If yes	, specify Cuben,	Maxican, Pu				E — American Indian, ck, White, etc.	
BY	3 Widowed 4 X Divorced	IF YES, GIVE WAR OR D	DATES	1 🗆	YES 2 X NO	Specify:			Spec	· ·	
	15. DECEDENT'S EDU	ICATION .	16a. OECEDENT'S	1101111 00011						/hite	
1	(Specify only highest grade			work done durin	most of working		166, KIND	OF BUSINESS/I	NUUSTRY		
"	Elementary/Secondary (0-12)	College (1-4 or 5+)					١.,				
₩.		6	Arti	st			Set	f-empl	oyed		
COMPLETED	17. FATHER'S NAME (First, Middle, Last)				18. MOTNE	R'S NAME (First, Middle, I	Maiden Surname)		
BE	Lee Price Calf	fee			Car	rie	Lavin	ia Whi	tehea	d	
	19a. INFORMANT'S NAME (Type/Print)		19b. MAILING	ADDRESS (St	eet and Number or	r Rural Route	Number, City	or Town, State,	Zip Code)		
2	Patricia M. Frier	nd	Sam	e as l	0						
	20a. METNOD OF DISPOSITION		b. PLACE AND DATE				DATE 2	De. LOCATION	- City or T	own State	
	1 - Burial 2 Cremation 3 - Ram	noval from State Co.	metery, cremetory or o	ther plece)		-					
	4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LI	OFMORE	Chesapeak	e Crem	atory E AND AODRESS			Betts.	ттте,	Maryland	
	21. SIGNATURE OF FUNERAL SERVICE LI	CENSEE /		Ran	p Funer	al Se	rvice	s. P.	Α.		
	> Ellen -	N. Ka	14							MD 20910	
	23. PART I. Enter the diseases, or	complications that cause	d the death. Do							Approximate	
		List only one cause on		TOT WINEY THE	mode of dying	y, such as	Cardioc of	respiratory	arrwat,	Interval Between	
	IMMEDIATE CAUSE (Final disease or condition										
	resulting in death) a. A dens car cinoma of hing I months DUE TO (OR AS A CONSCOURNCE OF):										
		DUE TO (OR AS	A CONSEQUENCE O	F):			1	and the same of th			
z											
CERTIFICATION	Sequentially list conditions, if any, leading to immediate	DUE TO (OR AS	A CONSEQUENCE O	F):							
\A	cause. Enter UNDERLYING										
Ĕ	CAUSE (Disease or injury that initiated events	DUE TO (OR AS	A CONSEQUENCE O	F):							
토	resulting in death) LAST										
빙		0.									
	PART ii. Other algnificent condition	na contributing to deeth	but not reculting	in the under	lying ceuee giv	ven in Pari		MAS AN AUTOPS	Y 24	b. WERE AUTOPSY FINDINGS	
EDICAL	Avteriosclerof	in Hours	DISPAN					PERFORMED?		AVAILABLE PRIOR TO COMPLETION OF CAUSE	
8		The second					· ' ' '	YES 2 NO		OF DEATH?	
Σ	DID TOPACCO HEE COL	DIDLITE TO CALLES	DE DEATH M	rc 🗆	W 1010-	DTAB: 5	٦			1 - YES 2 X NO	
PHYSICIAN:	DID TOBACCO USE CONT	KIBUIE IO CAUSE (RTAIN [
3	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLACE OF DEA	TN (Check only	one)						
Si	1 TES 2 X NO	1 Inpatient 2 ER/Out	tpatient 3 🗆 DOA		Home 5 X Resi	idence 6	Other (Speci	ify)			
Ξ	27. MANNER OF DEATH	26a. DATE OF INJURY (Month, Day, Year)		IE OF 280	. INJURY AT WORK?	280	d. DESCRIBE	NOW INJURY	OCCURED		
	1X Natural 5 Pending	(month, Day, real)	110		YES 2	NO					
ВУ	2 DACCION	28a. PLACE OF INJUR	Y — At home, farm,	atreet, factory,	office	281	LOCATION	(Street and Num	ber or Rural	Route Number.	
	3 Suicide 6 Could not be 4 Nomicide determined	building, atc. (Sp.	ecify)			1111	City or Town				
								_			
ם		GICIAN: To the best of my kno	wledge, death occurr	red at the time,	data and place, a	and dua to ti	he cause(s) a	and menner as a	stated.		
COMPLETED	one) 2 MEDICAL EXAMIN	ER: On the beals of exeminati	on and/or investigation	on, in my opini	on, death occured	d at the time	, data and pl	lecs, and dus to	the cause	(a) and manner as stated.	
	29b. SIGNATURE AND TITLE OF CERTIFIE	R ,			29c. LICEN	ISE NUMBER	R.,	29d. D	ATE SIGNE	D (Month, Day, Year)	
BE	Peter S Bin	ck MD			D	1501	60				
2	30. NAME AND ADDRESS OF PERSON WI		EATN (ITEM 27) (T-	Print1		- 0	-	I D	ecemi	er 3, 1995	
	Peter S. Birk,				ດ #T_າ	o cil	Van C	nring	MD	20902	
				AVEIIU	c, π1-2	, 011	rACT 2	hr Tild,	טויו	20002	
	31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIG	NATURE								
	DEC 04 199	5 Julia David	hor Markadi								



BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

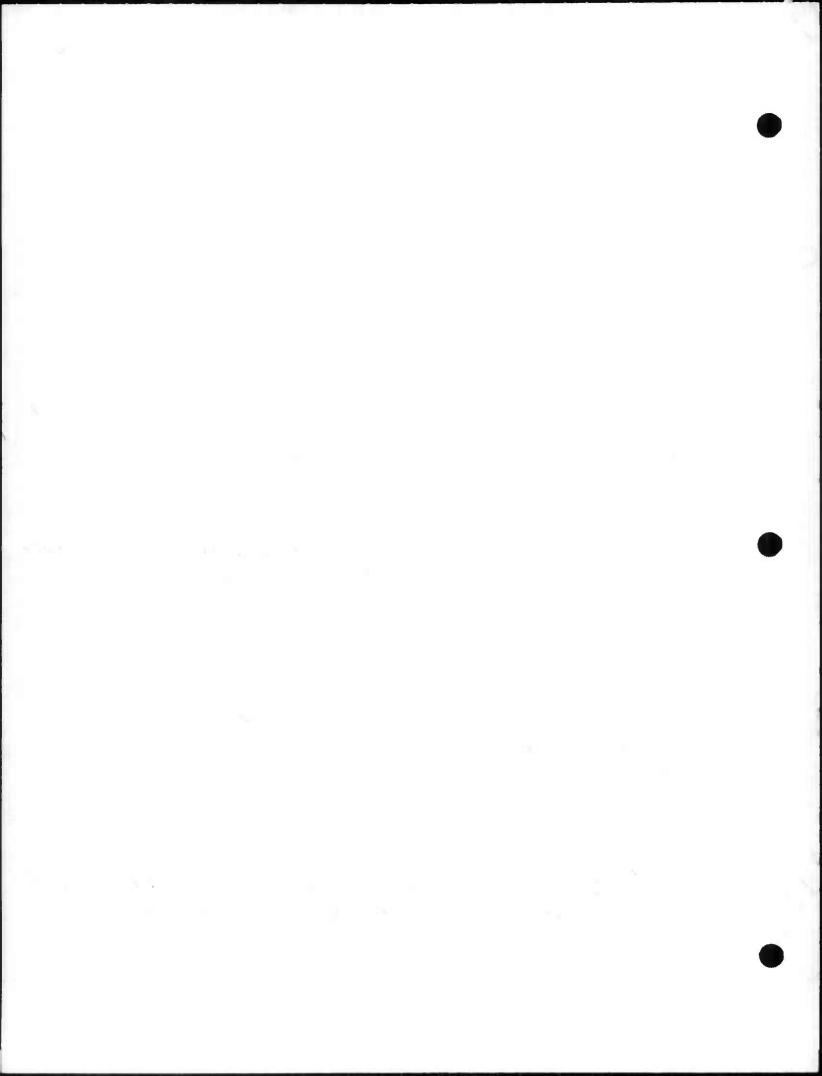
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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

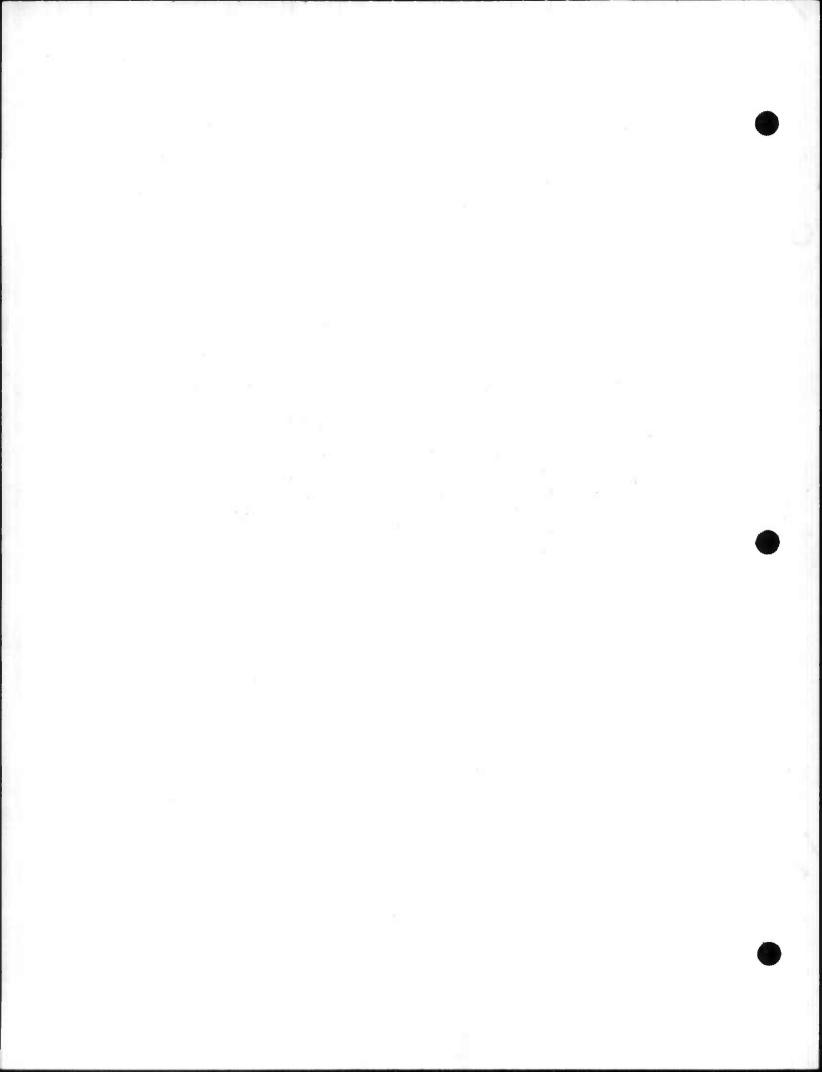
	1. DECEDENT'S NAME (First,	Middle, Last)				TOATE		DLA		2 DATE	OF DEATH				
			rginia M	laa lila	11000	e Cobb				MONTH DAY YEAR			3. TIME OF DEATH		
	4. SOCIAL SECURITY NUMB		5. SEX	6. AGE (In yrs.		IF UNDER		IF UNDER	04 1890	November 30, 1995 6:10 P			6:10 P		
	579-10-7582		1 M 2 XF	87	YRS.	MONTHS	DAYS	HOURS	MIN.	(Monti	Day Vanci	1000	Country)		
	Sa. FACILITY NAME (If not in			07							23,	1908		Ohio	
œ								OR LOCATIO		EATH			INTY OF		
6	Holy Cross	HOSPI	tal			Si	Llve	r Spi	ring			Moi	ntgor	nery	
S S						Y, TOWN C	OR LOCA	TION						10d. INSIDE CITY	
8	Maryland	Princ	ce George	215	Hv	attsv	/ill	e						LIMITS?	
7	100. STREET AND NUMBER						-	f. ZIP CODI	E			10a, CIT	IZEN OF	WHAT COUNTRY?	
8	7304 Riggs Road, #107							2078	} 3					States	
BY FUNERAL DIRECTOR	11. MARITAL STATUS	noda,	12. WAS DECEDEN	IT EVER IN U.S.	ARMED	13.	WAS DEC			HC OBIGIN	7 (Specify Yes			E - American Indian,	
E	1 Never Married 2 Married FORCES? 1 X YES 2 N						If yes, sp	ecify Cube 2 X NO	n, Mexica	n, Puerto I	Rican, atc.)	W 110-	Blac	k, White, atc.	
	3 🕅 Widowed 4 🗌 Divo	rced		WW IT			I TES	2 LX NO	Specny	ŗ.			Spec	/hite	
COMPLETED		EDENT'S EDUC		16a.	DECEDENT'S					16b.	KIND OF BU	SINESS/IN		111100	
H	Elementary/Secondary (0	highest grade	College (1-4 or 5		(Give kind of life. Do NOT u	work done (se retired.)	during mo	est of workin	g						
릴			3		minist	rati	ve /	Assis	tant	: l n	eparti	nent.	of A	lrmv	
S	17. FATHER'S NAME (First, MI	iddle, Last)								_	Aiddle, Maiden		01 /	iz iiiy	
	William C	ampbe]	11					Etta			olling				
BE	19a. INFORMANT'S NAME (7)				19b. MAILING	ADDRESS	(Street a	-			er, City or Tow		n Codel		
2	Clyde R. W	allace	2			as					, ony or 1011	ri, Otaro, ari	p ddde,		
	200 METHOD OF DISPOSITI	ON		20b. PLAC	E AND DATE			ame of		DATE	200 10	CATION —	City or Tr	num State	
- 8	1 Buriel 2 Corematio		oval from State	cametery, o	eremetory or o	ther place)	rom	2+02V	,					Maryland	
9	21. SIGNATURE OF FUNERAL		ENSEE)	sapec	22.	NAME A	ND ADDRES	SS OF FAC	DILITY -	Z [Deli	72 A T T	Lie,	матутапи	
	5000	. 4	1 N			Ra	pp [uner	al S	Servi	ces, f	P. A.			
	23. PART I. Enter the di	XX	V. / G	GA			3 G:	ist A	venu	je, S	ilver	Spri	ing,	MD 20910	
CERTIFICATION	IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST Interval Between Onset and Death														
	PART II. Other significan	nt condition	s contributing to	death but no	resulting	In the un	derlylo	COURS O	duen in I	Part (24a. WAS AN	ALIMORAN	1		
MEDICAL					. rounding		out y m	9 00030 5	114011 111	raint t.	PERFOR		246	WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE	
										- 1	1 TYES 2	NO		OF DEATH?	
	DID TOBACCO US	SE CONITI	DIDLITE TO CA	LICE OF DE	ATLL VI	C []	10 F	1 1010	EDTAIN					1 TYES 2 NO	
AN	25. WAS CASE REFERRED TO		CIBUTE TO CA		ACE OF DEA			UNC	ERTAIN	ואַי					
S	EXAMINER?	, medicale	HOSPITAL:			OTHER	1:		Carlo start						
PHYSICIAN:	1 TYES 2 NO		1 inpatient 2 28a. DATE OF		3 DOA			e 5 🗆 Re	sidence						
BY PI	1 Natural 5 🗆 I	Pending nvestigation	(Month, D	ay, Year)	1NJ	M	1 🗆 1	RK7 YES 2] NO	28d. DES	CRIBE HOW I	NJURY OC	CURED		
		Could not be letermined	26a. PLACE O building,	F INJURY — At I etc. (Specify)	home, farm, :	street, facto	ory, offic			281. LOCA City o	ATION (Street a or Town, State)	and Number	r or Rural I	Route Number,	
COMPLET	29a. CERTIFIER (Check only	FYING PHYSIC	CIAN: To the best of	my knowledge,	death occurr	ed at the ti	me, date	and place,	and due	to the cau	se(s) and mer	ner as sta	ted.		
Š	one) 2 MEDIC	CAL EXAMINE	R: On the basis of an	camination and/	rinvestigation	n, In my o	pinion, d	eath occur	ed at the t	time, date	end place, en	d due to ti	he cause(s	a) and menner ee stated.	
BE C	296, SIGNATURE US TITLE	DERT ELER	11	1.	1			29c. LICE	NSE NUM	BER		29d. DAT	E SIGNED	(Month, Day, Year)	
	-ways	1/	/	74	M	0		DO	112	-0		P	EC	1, 1995	
2	30. NAME AND ADDRESS OF	PERSON WHO	COMPLETED AUS	SE OF DEATH (IT					-						
	WHITER E	-60	020 MI	0 270	9940	REI	AE	w	2079	DO I	WHE	ATD	NI	47 20902	
	31. DATE FILED (Month, Day,)		32. REGISTRA	R'S SIGNATURE										/ L000E	
pill.	111111111	4 1995	Julia all	welson Re	dan.										
	Claw V.	エーブプリ													



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	1 - STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.								
	1. DECEDENT'S NAME (First, Middle, Lest) ALBERT	J	CHAM	BERS	SR	2. DATE OF DEATH		3. TIME OF DEA 21. 45	P M
	4. SOCIAL SECURITY NUMBER 723-14-6816	13€ M 2 □ F 65	yrs. lest birthdey) YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS, HOURS MIN.	7. DATE OF BIRTH (Month, Day, Yea Apr 26,	1930	BIRTHPLACE (State or Fi Country) Maryland	
TOR	90. FACILITY NAME (If not institution, give s Shady Grove Ad RESIDENCE OF DECEDENT		spital		R LOCATION OF D		9c. COUNTY Mon	tgomery	
DIRECTOR	10e. STATE 10b. COUNTY	tgomery		r, town or Locat				10d. INSIDE CITY LIMITS? 1 YES 2	
FUNERAL		ytown Drive	2,		21P CODE 0 8 5 4		50000000	N OF WHAT COUNTRY?	
B	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN 1 FORCES? 1 YES IF YES, GIVE WAR OR DAT	2 NO		city Cuban, Mexico	NIC ORIGIN? (Specify an, Puerto Ricen, etc. ly:		Black Black	ien,
PLETED	15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12)		(Give kind of w life. Do NOT use		st of working		BUSINESS/INDUS		
at once.	6th Grade 17. FATHER'S NAME (First, Middle, Last) Alonzo Ch	ambers	Lab	orer		No ME (First, Middle, Mai Ssie Fr			
medical examiner must be notified at once. TO BE COM	190. INFORMANT'S NAME (Type/Print) Mrs Ethel Ch	(Wife) ambers			nd Number or Rural	Route Number, City or	Town, State, Zip Co	, Md #20	854
r must be	20e. METHOO OF DISPOSITION 100 Burlel 2 Cremetion 3 Rem 4 Donation 5 Other (Specify)	oval from State	PLACE AND DATEO	Heaven	Cem.	12/5	Silver	y or Town, State c Spring,	Md
examine	21. SIGNATURE OF FUNERAL SERVICE LIC	? Anone	lur	Snov 246	N. Was	neral H	St. R	A. 20850 ockville	. Md
23. PART I. Enter the diseases, or complications that caused the daeth. Do not enter the mode of dying, such ahock, or haert failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) B. CARCING MA LUNG DUE TO (OR AS A CONSEQUENCE OF):						ch aa cardiac or n	espiratory arrest	t, Approxim	Between d Death
or other traumatic	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): C. DUE TO (OR AS A CONSEQUENCE OF): d								
es any inju	PART II. Other algnificent conditions contributing to death but not resulting in the underlying ceuse given in Part I. 24s. WAS AN AUTOPSY PERFORMED? 1 VES 2 J. NO							24b. WERE AUTOPSY F AMAILABLE PRIOR COMPLETION OF OF DEATH?	CAUSE
A A	DID TOBACCO USE CONTI 25. WAS CASE REFERRED TO MEDICAL EXAMINER?	/ 20	DEATH YE	H (Check only one)	UNCERTAI	NB			
5 >	1 PYES 2 NO	HOSPITAL: 1 Inpetient 2 ER/Outpet 28e. OATE OF INJURY				8 Other (Specify)	M IN RIEW ACCUS	250	
1 Netural 5 Pending (Month, Dey, Year) INJURY WORK? 1 VES 2 NO									
m 28 ls ETED	3 Suicide 8 Could not be determined 28. Could not be building, atc. (Specify) 28. PLACE OF INJURY — At home, tarm, streel, factory, office 28. LOCATION (Street and Number or Rural Route No. 1) City or Town, State)							Rural Route Number,	
APL te		CIAN: To the best of my knowled R: On the beele of examination							stated.
O BE CO	29b. SIGNATURE AND TITLE OF CERTIFIES	Muylesh	lles		29c. LICENSE NU	MBER 99	29d. DATE S	IGNED (Month, Day, Year)	3
-	30. NAME AND ADDRESS OF PERSON WH	144E 10215	FER	Print) NWOOL	RDg	BETHES	SA MS	208171	1106
	31. DATE FILED (Month, Day, Year)	32 REGISTRAR'S SIGNAT	TUHE						





MARYLAND

10g, CITIZEN OF WHAT COUNTRY?

UNITED STATES

Specify:

9c COUNTY OF DEATH

MONTGOMERY

3. TIME OF DEATH

1:30

10d. INSIDE CITY

14. RACE — American Indian, Black, White, etc.

WHITE

interval Batween

Onset and Death

24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?

1 YES 2 NO

29d. DATE SIGNED (Month, Day, Year)

N YES 2 □ NO

8. BIRTHPLACE (State or Foreign

P

REG. NO

1995

2. DATE OF DEATH

DEC. 1,

FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

4. SOCIAL SECURITY NUMBER

SOPHYE B. COHEN

5. SEX

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7. DATE OF BIRTH (Month, Day, Year) HOURS 579-42-4800 1 M 2 XF 91 YRS. NOV. 1904 permit, Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street end number, 96. CITY, TOWN OR LOCATION OF DEATH DIRECTOR HEBREW HOME OF GREATER WASHINGTON ROCKVILLE RESIDENCE OF DECEDENT 10b. COUNT 10c. CITY, TOWN OR LOCATION MARYLAND MONTGOMERY ROCKVILLE 10e. STREET AND NUMBER FUNERAL 101, ZIP CODE 6121 MONTROSE ROAD funeral director, page 5 should be detached for use as the burial-transit 20852 retained by the hospital or attending physician. 11 MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No-1 Never Married 2 Merried If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 YES 2 NO Specify: BY 3 X Widowed 4 Divorced COMPLETED 16e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify College (1-4 or 5+) 12 CLERK/TYPIST VETERANS ADMINISTRATION once. 17. FATHER'S NAME (First, Middle, Lest) 16. MOTHER'S NAME (First Middle Maiden Sumame) 10 JOSEPH BERNSTEIN BE SARAH MAZOR notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 FAYE FIRST (DAUGHTER) 715 NORTHWOOD TERRACE-SILVER SPRING, MD 20902 death. Page 6 may be be 20a METHOD OF DISPOSITION
1 N Buriel 2 Cremetton 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION /Name of must DATE 20c. LOCATION — City or Town, State 4 Donation 5 Other (Specify) ADAS ISRAEL 12-3 WASHINGTON, DC 21. SIGNATURE OF FUNERAL SERVICE LICENSEE examiner BANZANSRY GOLDBERG MEMORIAL CHAPELS INC. 1170 ROCKVILLE PIKE-ROCKVILLE, MD 20852 n and completely filled in by the to burial, cremation, or removal. hours after medical 23. PART I. Enter the diseasea, or complications that caused the desth. Do not anter the mode of dying, auch as cerdiac or respiratory arrest, shock, or haert failure. List only one cause on each line. IMMEDIATE CAUSE (Final the disease or condition RESPIRATORY FAILURE event, resulting in death) DUE TO (OR AS A CONSEQUENCE OF executed 1 traumatic CERTIFICATION Sequentially list conditions, if sny, leading to immediate DUE TO (OR AS A CONSEQUENCE OF): been signed by the attending physician it, of Health and Mental Hygiene prior to death certificate be cause. Enter UNDERLYING CAUSE (Disease or injury other DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 10 PART II. Other algnificent conditions contributing to death but not resulting in the underlying ceuse given in Part i. the MEDICAL 24a. WAS AN AUTOPSY PERFORMEO? TUBERCULOSI requires that amy 1 TYES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \square NO \square UNCERTAIN \square PHYSICIAN: has by Dept. AMP. 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) certificate I HOSPITAL OTHER:
4 Defursing Home 5 Residence 6 Other (Specify) ATTENDING PHYSICIAN: 1 TES 2 NO Inpatient 2 - ER/Outpatient 3 - DOA 10 27. MANNER OF DEATH 26a. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT 26d, DESCRIBE HOW INJURY OCCURED marked, After this co 1 Netural 5 Pending Investigation М 1 YES 2 NO BY 2 Accident 28e. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify) 3 Sulcide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 99 COMPLETED 6 Could not be DIRECTOR: A 4 Homicide 28 determined ltem men 29e. CERTIFIER
(Check only)

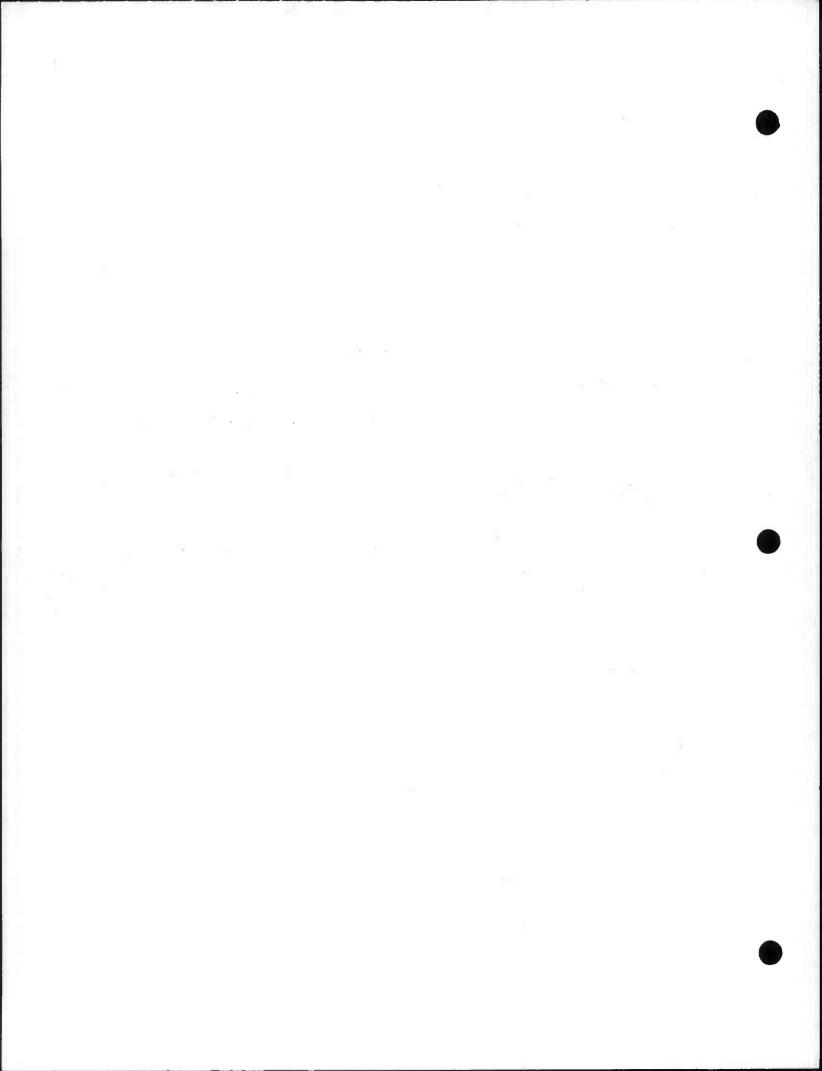
1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(e) end manner as stated. 80 (Check only one) HOSPITAL FUNERAL within 72 -TO THE HOSPITA
TO THE FUNERAL
Be filed within 72
IMPORTANT: II 2 ___ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(e) and manner as stated. 296. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER BE 05885 Bapa enen 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) STEVEN 6121 MONTROSE RD, ROCKVILLE 31. DATE FILED (Month, Day, Joar) 32. REGISTRAR'S SIGNATURE Talia Davidesa Ran 04 1995

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

IF UNDER 1 YEAR IF UNDER 24 HRS.

6. AGE (In yrs. last birthday

DHMH-16 Rev 1/89



BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	is certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	ile event, the medical examiner must be notified at once.
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be exer	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the furbe filed within 72 hours after death with the State Dept. of Health and Memtal Hygiene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	REGISTRAR		CERTIFI	CALE	F DEATH	REG. NO.		
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH MONTH DAY	YEAR	3. TIME OF OEATH
	JAMES	R. COX				DEC. 5,	1995	6:55 PM
	4. SOCIAL SECURITY NUMBER 578-10-0292	5. SEX 6. A	GE (In yrs. lest birthday) 92 YRS.	MONTHS DAY		7. DATE OF BIRTH (Month, Day, Year) JULY 24,19	Coun	HPLACE (State or Foreign (ry)) SH. D.C.
R	9a. FACILITY NAME (If not institution, give stre MAGNOLIA GARDENS		HOME		NHAM		c. COUNTY OF	
5	RESIDENCE OF DECEDENT	7 1101102110	110125	110	MILENI		FILING	E GEUNGES
DIRECTOR	MD. PRINC	E GEORGES		TOWN OR LO	CATION VILLE			10d. INSIDE CITY LIMITS? 1 YES 2 NO
	10e. STREET AND NUMBER			1 01410	10f. ZIP CODE	1	0g. CITIZEN OF	WHAT COUNTRY?
FUNERAL	2742 LORRING				20747			.S.A.
B	1 Never Merried 2 Merried 3 Widowed 4 Divorced	12. WAS DECEDENT EV. FORCES? 1 X IF YES, GIVE WAR C	PES 2 NO	If yes	DECENDENT OF HISPA, specify Cuben, Mexic. YES 2 NO Specific		No — 14. RAC Blac Spec	E — American Indian, ok, White, etc.
	15. DECEOENT'S EDUCA (Specify only highest grade of		18e. DECEDENT'S	ISUAL OCCUP	ATION	16b. KIND OF BUSIN	ESS/INOUSTRY	
COMPLETED	Elementary/Secondary (0-12)	College (1-4 or 5+)	Ille. Do NOT use	retired.)	most of working	TDA T	INTING	
8	17. FATHER'S NAME (First, Middle, Lest)		2433.6	A PALL		AME (First, Middle, Maiden Sur		
	HARRISON	CROOK				UNKNOWN	name,	
H H	19a. INFORMANT'S NAME (Type/Print)	021001		ADDRESS (Stre	et and Number or Rural	Route Number, City or Town, S	itate. Zip Codel	
2	ALICE V. COX		SAME		ITEM #10		mid Ep Occop	
	20e. METHOD OF DISPOSITION 1 □ Burlat 2 ☑ Cremetion 3 □ Ramov	ral from State	20b. PLACE AND DATE Of cemetery, crematory or oth	FOISPOSITION er place)	(Name of	DATE 20c. LOCAT	TION — City or T	
- 1	4 Donation 5 Other (Specify)	MEEE	CHAMBERS		TORY AND ADDRESS OF FA		ERDALE	MD
	1/2/ Chi	mbersa	M0009			RS CO., RIVE	TATE	MD 20727
TION	disease or condition as a consequence of: a. Due to (SRI AS A CONSEQUENCE OF): Due to (SRI AS A CONSEQUENCE OF):						Action comes as become	
CERTIFICATION	cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (OB	ASIA CONSEQUENCE OF	Pas	lure	J		10 pe
	PART II. Other eignificent conditions	contributing to deel	th but not resulting in	the underly	ing cause given in	Part I. 24s. WAS AN AU		. WERE AUTOPSY FINDINGS
EDICAL	Pros	aute (sa,	CC	PD	PERFORME		AVAILABLE PRIOR TO COMPLETION OF CAUSE
MEC	Ane	una						OF DEATH? 1 YES 2 NO
	DID TOBACCO USE CONTRI			1 NO	☐ UNCERTAI	N D		
×	25. WAS CASE REFERRED TO MEDICAL EXAMINER?		28. PLACE OF DEATH	(Check only o				
Si	1 TT 1100 1 TT 16	HOSPITAL: 1 Inpetient 2 ER/		OTHER:	Iome 5 - Residence	6 ☐ Other (Specify)		
BY PHYSICIAN:	27. MANNER OF DEATH 1 Netural 5 Pending 2 Accident Investigation	28e. DATE OF INJU (Month, Day, Ye		RY	INJURY AT WORK? YES 2 NO	28d. DESCRIBE HOW INJU	RY OCCURED	
	3 Suicide 6 Could not be determined	28s. PLACE OF INJ building, etc. (URY — At home, farm, at Specify)	rest, factory, o	ffles	26f. LOCATION (Street end City or Town, State)	Number or Rural	Route Number,
COMPLET						to the ceuse(e) and manner time, date end place, and d		s) end manner ee stated.
# F	PM. SIGNATURE AND JUTLE OF CENTURES	WI			D3486		DATE SIGNED	(Viorith, Day Year)
۵ 🖡	30. NAME AND ADDRESS OF PERSON WHO	CON LETED CAUSE OF	DEATH (ITEM 27) (Type. /	Print)	J 3400	,	, _	10/11
	DR. OLEG B. SH	HAK M.D.	9470		LIS RD.,	LANHAM, MD.	/	•
	31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE DEC 08 1995 Separative functions 32. REGISTRAR'S SIGNATURE							

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31. DATE FILED (Movim, Day, Hear)

04 1995

32. REGISTRAR'S SIGNATURE Jalin Studior Revelate

DIRECTOR

Pages 1, 2, 3

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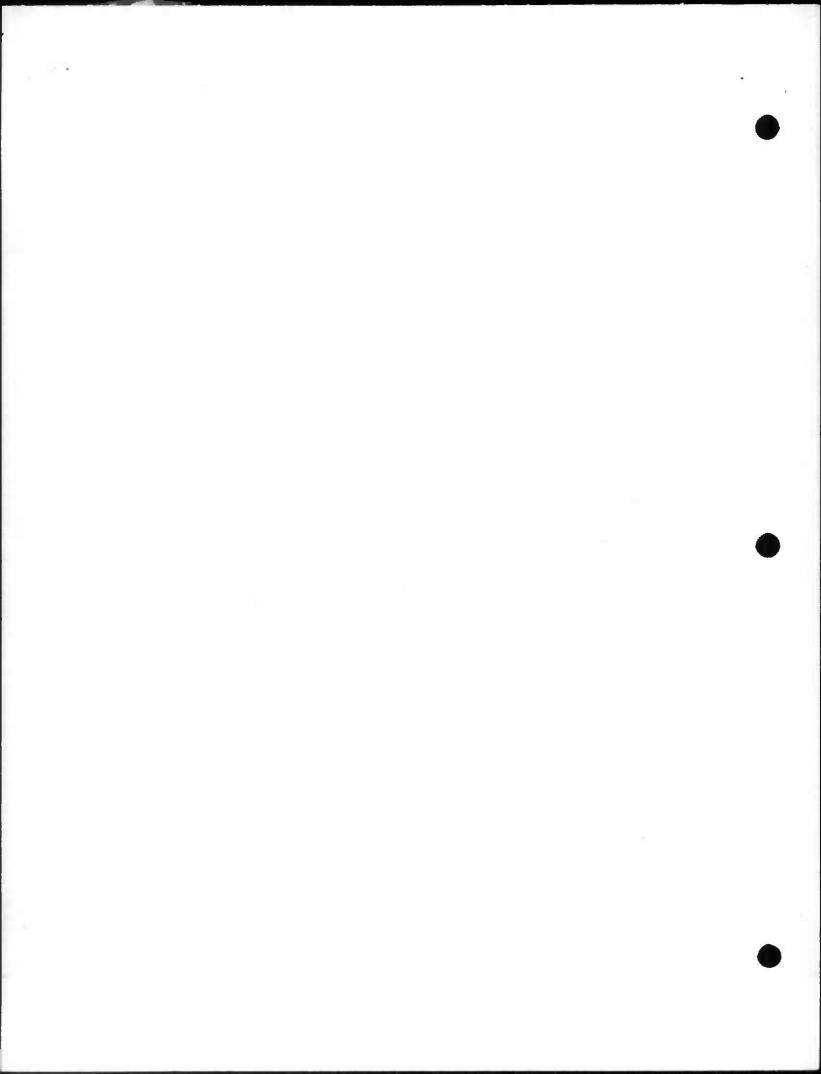
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1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last, 2. DATE OF DEATH 3. TIME OF DEATH JOHN J. CASCIO JOHN CASSCIO 1995 December 2:10 AM A SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year) BIRTHPLACE (State or Foreign Country) DAYS HOURS MIN. 1 😾 M 2 🗆 F YRS 577-22-7239 78 07/20/1917 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR CARRIAGE HILL - BETHESDA BETHESDA MONTGOMERY RESIDENCE OF DECEDENT 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Montgomery Silver Spring 1 YES 2 NO FUNERAL 10a. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 15301 Beaver Brook Court Apt.911B 20906 USA 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☑ YES 2 ☐ NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, White, etc. 1 Never Married 2 🔀 Married If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ YES 2 ☒ NO Specify: ВУ 3 Widowed 4 Divorced Specify: White WW II COMPLETED 16e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest g Elementary/Secondary (0-12) College (1-4 or 5+) 8 Barber Self Employed 17. FATHER'S NAME (First, Middle Last) 18. MOTHER'S NAME (First, Middle, Meiden Surname) 76 Sam Cascio Maria Sparacino BE notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20906 2 15301 Beaver Brook Court, Apt 911B, Silver Spring, MD Grace D. Cascio 99 20s. METHOD OF DISPOSITION

1 🖾 Buriel 2 🗆 Cremation 3 🗀 Removal from State

4 🗆 Donetion 5 🗀 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State DATE must Gate Of Heaven Cemetery 12/4/95 Silver Spring, MD examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY colo Francis J. Collins Funeral Home, Inc. 5 amop 500 University Blvd.W. Sil.Spr.MD 20901 medical 23. PART I. Egter the disesses, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, Approximate shock, or heart fallure. List only one cause on each line. Interval Between IMMEDIATE CAUSE (Final Onset and Death the disesse or condition STEDSAY LOW O resulting in death) event, traumatic CERTIFICATION Sequentielly list conditions, DUE TO (OR AS A CONSEQUENCE OF): If any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury other DUE TO JOR AS A CONSEQUENCE OF that initiated events resulting in death) LAST 6 mjury, PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS MEDICAL MAILABLE PRIOR TO Ì melassa COMPLETION OF CAUSE T NES 2 TWO shows 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF BEATH (Check only one) the man HOSPITAL I THE 2 WHO 1 | Inpatient 2 | ER/Outpatient 3 | DOA reing Home 5 [] Residence 6 [] Other (Specify) 8 27. MANNER OF DEATH 28s. DATE OF INJURY 28c. INJURY AT WORK? 38b. TIME OF INJURY 28d. DESCRIBE HOW INJURY OCCURED marked. 1 (Watura) M 1 YES 2 NO BY 2 Accident 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 22 28f. LOCATION (Street and Number or Rural Route Number City or Seen, Steps) COMPLETED # Could not be 4 | Homicide 82 1 CERTIFYING PHYSICIAN: Tyrthe best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. TO THE FUNERAL ID THE FUNERAL IDENTIFY TO THE FUNERAL IDENTIFY TO THE FUNERAL IT IS 2 MEDICAL PRAMINER: ON 288 SIGNATURE AND TITLE OF CERTIFIER 28r. LICENSE NUMBER BE DO Mr. 2 CAUSE OF DEATH (ITEM 27) (Type, Print)





BALTIMORE, MARYLAND 21215-0020	24 hours after death. Page 6 may be retained by the hospital or attending physician.	certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should in the State Dept, of Health and Memal Hygiene prior to burial, cremation, or removal.	ne medical examiner must be notified at once.	
DIVISION OF VITAL RECORDS, P.O. BOX 68760,	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: It Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.	

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TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1 - STATE REGISTRAR	IE UF MAKYL			OF DEAT		REG. NO.			
1. DECEDENT'S NAME (First, Middle, Last)						. DATE OF DEATH		3	. TIME OF DEATH
Deborah		601	-E			MONTH DAY	0	95	10:35p 11
4. SOCIAL SECURITY NUMBER 5. SEX 1 M	2 DF 6. AGE (in yrs. lest birthday) 43 YRS.	IF UNDER 1 Y	EAR IF UNDER 2		DATE OF BIRTH	52	8. BIRTHPL Country) Washi	ACE (State or Foreign
9e. FACILITY NAME (If not institution, give street end in	number)		9b. CITY, TO	WN OR LOCATIO			9c. COU	NTY OF DEA	
Hyattsville >	Manos		Hyat	tsville	, MD		Pri-	168	George's
RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY		18c, CIT	Y, TOWN OR L	OCATION				1	Od. INSIDE CITY
MD Prince	GOLFG	e's Hu	104	sville				1	LIMITS?
10e. STREET AND NUMBER	4 1	/		101. ZIP CODE			10g. CITI	ZEN OF WH	AT COUNTRY?
6500 Kiggs Ko	2				743			ed St	ates
1 Never Merried 2 XMerried FOR	DECEDENT EVER IN ICES? 1 1 YES ES, GIVE WAR OR OA	2 XNO	If yo	DECENDENT OF DECEMBER 1 SPECIFY Cuber. YES 2 KNO	, Mexican, I	ORIGIN? (Specify Yes (Puerto Ricen, etc.)	or No—	14. RACE — Black, N Specify:	- American Indian, White, etc. Black
15. DECEDENT'S EDUCATION (Specify only highest grade completes	t)	18e. DECEDENT'S	vork done durir	PATION ng most of working	,	16b. KIND OF BUSI	NESS/IND	USTRY	
Elementary/Secondary (0-12) Coilege	(1-4 or 5+)	life. Do NOT us	e retired.)		') t		
12 17. FATNER'S NAME (First, Middle, Lest)		Sec	cretar	-	EO'O MAME	(First, Middle, Melden S	riva	ite	
Thomas Johnson						t Dorsey	umame)		
19a. INFORMANT'S NAME (Type/Print)		19b. MAILING	ADORESS (Si			te Number, City or Town,	Stete, Zip	Code)	
Linda Ferguson		7229 1	ly1ton	Street	Seat	Pleasand	i, Mi	2074	43
20a. METNOD OF DISPOSITION 1 ☐ Buriel 2 □ Cremetlon 3 □ Removal from 4 □ Donation 8 □ Other (Specify)	State 20b.	PLACE AND DATE Of the control of the	ther place)	N(Neme of				Over,	
21. SIGNATURE OF FEMALAL BERVICE LICENSEE	n /	Tarmon			S OF FACIL				TID
+ alex. S. 1-	mae (p.				Pope Funer Pike Fore			MD 20747
23. PÁRT I. Enter the diseasea, or complica ahock, or heart failure. List only	tight that caused	the death. Do r							Approximata
IMMEDIATE CAUSE (Final disease pr condition	in en out to a section re	IMMUNE I	EFICT	ENCY SY	NDRON	/F			Interval Between Oneat and Death UNKNOWN
reaulting in death) a		CONSEQUENCE OF		DITOL DI	TYDICOL	113			UNKNOWN
Sequentially list conditions, b.									
If any, leading to Immediate cause. Enter UNDERLYING	DUE TO (OR AS A	CONSEQUENCE OF	7):						
CAUSE (Disease or Injury that Initiated events	DUE TO (OR AS A	CONSEQUENCE OF	ŋ:						
resulting in death) LAST									
PART il. Other algnificant conditiona contri	buting to death be	ut not reaulting	n the under	riving cause gi	ven in Pa	rt I. 24s, WAS AN A	UTOPSY	24b W	ERE AUTOPSY FINDINGS
PANCYTOPENIA, PNEUM		_				PERFORM	IED?	A	MAILABLE PRIOR TO OMPLETION OF CAUSE
			/			1 TYES 2X	"VNO		F DEATH?
DID TOBACCO USE CONTRIBUTE	TO CAUSE O	F DEATH YE	S E NO	UNCE	RTAIN				
25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSE		26. PLACE OF DEAT	N (Check only	one)					
1 YES 2 NO 1 inp	atient 2 - ER/Outpo		4 M Nursing	Home 5 🗆 Ree					
27. MANNER OF DEATH 280 280 280 280	(Month, Day, Year)	28b. TiM	URY	c. INJURY AT WORK?		Bd. DEŞCRIBE NOW IN.	JURY OCC	CURED	
2 Accident Investigation 3 Suicide & Could not be	. PLACE OF INJURY	— At home, ferm, a				Bf. LOCATION (Street en	d Number	or Rural Bou	te Number
4 Homicide 8 Could not be determined	building, etc. (Speci	ily)				City or Town, Stete)			
290. CERTIFIED PHYSICIAN: To	the best of my knowl	edge, death occum	ed at the time,	date end place,	end due to	the Cause(s) and mann	er ee stat	ed.	
one) 2 MEDICAL EXAMINER: On the									nd manner ee stated.
280. SIGNATURE AND TITLE OF CERTIFICA	wk	MM)	DO	01499		▶ De	cembe	r 7, 1995
38. NAME AND ADDRESS OF PERSON WHO COMPL LEWIS HILLIARD DENNIS	, M.D.,	ATN (ITEM 27) (Type P.A. 62	O1 GRI	EENBELT	ROAD	#U-1 COL	LEGE	PARK	, MD 20740
31. DATE FILEO (Month, Day, Year) 32.	RESISTRAD'S SIGN	ATURE							
DEC - 8 1995									

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S	#	8	ě
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	tuneral, pirectors: after this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the by	within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	ANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
5	逆	P.	5
5	5	F	Z

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

1 - STATE REGISTRAR		STATE OF MARYL	AND / DEPAR CERTIF				MENTA	REG. NO.			
1. DECEDENT'S NAME (Flost RUSSEL		FADDEN	CA	RTE	R		MON	e of death th day ember	4,19	3. 95	2:52 P M
4. SOCIAL SECURITY NUMBER 230-22-845	-	SEX 6. AGE	70 YRS.	IF UNDER		#F UNDER 24 HRS HOURS MIN.	(Mor	E OF BIRTH th, Day, Year)		Country)	MCE (State or Foreign
90: FACILITY NAME (# not in Fort Washin	gton Ho					LOCATION OF Shingto	DEATN		9c. COUNTY	OF DEAT	
RESIDENCE OF DEC	10b. COUNTY		10c CIT	Y. TOWN O	R LOCATI	ON.					d. INSIDE CITY
Maryland		Georges		.,	ashi	ngton,	Mary	land		17	LIMITS? YES 2 NO
9011 Mill	Street				101.	20744					tates
11. MARITAL STATUS 1 Never Married 2 3 Dividowed 4 Dividowed	Married	2. WAS DECEDENT EVER IF FORCES? 1 XYES IF YES, GIVE WAR OR D	2 NO	11	f yes, spec	NDENT OF NISI city Cuben, Mex NO Spi	Ican, Puerlo	IN? (Specify Yes o Rican, etc.)	or No 14	Specify:	American Indian, /hita, etc. Black
	EDENT'S EDUCAT	ION	16a. DECEDENT'S	USUAL OC	CCUPATION	l adapartitan	16	Sb. KIND OF BUSI	NESS/INDUS	TRY	
Elementary/Secondary (College (1-4 or 5+)	(Give kind of a life. Do NOT us	se retired.)			er.	Go	vernm	ent	
17. FATHER'S NAME (First, A Edward Car								, Middle, Maiden S aunders	iumame)		
190. INFORMANT'S NAME (Loette Ca								mber City or Town hington			4
20a, METHOD OF DISPOSIT 1 ABurtal 2 Crematic 4 Donation 5 Othe	on 3 🗌 Remove	of from State cer	netery, cremetory or o	ther plece)			1		ation — cir heltei		
21, SIGNATURE OF FUNERA	AL SERVICE LICEN		VC JC I	22.	NAME AND	ADDRESS OF	FACILITY PO	pe Fune	ral H	omes	MD 20747
IMMEDIATE CAUSE (FI disease or condition resulting in death)	neart fallure. Lis	Ceneralize C	each ilne.								Approximate Intervsi Batween Onset and Dasth
Sequentially list condi- if any, leading to imme- cause. Enter UNDERLY CAUSE (Disease or inj- thet initiated avants resulting in death) LAS	odlate ING ury c.		A CONSEQUENCE O								
PART if, Other signitic								24a. WAS AN A PERFORM	MED?	AV CC	ERE AUTOPSY FINDINGS MILABLE PRIOR TO DMPLETION OF CAUSE F DEATN? YES 2 NO
25. WAS CASE REFERRED		BUTE TO CAUSE (28. PLACE OF DEA			UNCERT	AIN 🗆				
EXAMINER?		HOSPITAL:	patient 3 XDOA	OTHER 4 Nur		5 🗆 Rasiden	ce 6 🗆 Ot	her (Specify)			
27. MANNER OF DEATH 1 Netural 5 2 Accident	Pending Investigation	28a. DATE OF INJURY (Month, Day, Year)	28b. TM	AE OF JURY M	28c. INJL WOI 1 Y		28d. D	ESCRIBE HOW IN	JURY OCCU	RED	
0 0 0 1111	Could not be determined	26a. PLACE OF INJUR building, etc. (Spi	Y — A1 home, farm, scrify)	street, fact	tory, office			OCATION (Street a ity or Town, State)	nd Number o	Rural Rou	te Number,
anni omy		AN: To the best of my kno-									nd manner as stated.
29b. SIGNATURE AND TITL	- MO					29c. LICENSE D259	25		▶ De	24,	Inth, Day, Year)
J, BERGER	了		PISCONS	o, Print)	Tve,	BeTh	esda	-, Md	208	74	
31. DATE FILED (Month, Day	8 1995	32. BEGISTRAR'S SIG	nature nor Rankell								

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BALTIMORE, MARYLAND 21215-0020	ith. Page 6 may be retained by the hospital or attending physicia
	24 hours after dea
DIVISION OF VITAL RECORDS, P.O. BOX 68760	ITENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the
VISION OF VITAL	L OR ATTENDING PHYSICIAN; The Ia

PHYSICIAN: The law requires that the death certificate be executed within Z4 hours after death. Page 6 may be retained by the hospital or attending physician.	This certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be considered by the attention of the page 1, 2, 3 should be considered by the attention of the page 1, 2, 3 should be considered by the attention of the page 3, 3, 3, 3, 3, 3, 3, 3, 3, 3, 3, 3, 3,	e medical examiner must be notified at once.
G	TIDE: After this certificate has been signed by the attending physician and completely filled in by the	are used with the Case Copy. Or regul and regular trygene proof of chemicals, or lettings.
VID THE HOSPITAL OR ATTENDIN	THE FUNERAL DIRECTOR: After	IMPORTANT: If item 28 is marke

	1 - STATE REGISTRAR	STATE OF MARYL	AND / DEPART	MENT OF I	EALTH AND	MENTAI	HYGIEN					
	1. DECEDENT'S NAME (First, Middle, Last	The control										
	Elizabeth Mary	y Cockrell				Dece		4, 19	YEAR Q 5	4:30 p M		
	4. SOCIAL SECURITY NUMBER	4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH								PLACE (State or Foreign		
	161-22-3069	1 □ M 2 😾 F	67 YRS.	ONTHS DAYS	HOURS MIN.		31,]	927	Country	nsylvan i a		
	9e. FACILITY NAME (If not institution, give	street and number)	-	b. CITY, TOWN	OR LOCATION OF D		J1, 1		TY OF DI			
۳ ا	5601 40th Avenue Hyattsville Prince George's											
ธิ	RESIDENCE OF DECEDENT											
DIRECTOR			18c. CITY,	TOWN OR LOCA	TION					10d. INSIDE CITY		
		ice George's	Hyat	tsvill	е				1 X YES 2 NO			
₹	10s. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WH/								HAT COUNTRY?			
剪	The state of the s	5601 40th Avenue 20781 U.S.A.										
FUNERAL	11. MARITAL STATUS 1 Never Married 2 Merried	12. WAS DECEDENT EVER I		13. WAS DEC	ENDENT OF HISPA ecify Cuben, Mexic	NIC ORIGIN	? (Specify Yes	or No-	14. RACE Black	- American Indien, White, atc.		
B	3 Widowed 4 Divorced	IF YES, GIVE WAR OR D		1 TYES	2 NO Speci		,		Specif			
	15. DECEDENT'S ED	LICATION	18+. DECEDENT'S US	IIAL OCCUPATION	NAI	Lan		- 1		WIIILLE		
COMPLETED	(Specify only highest grad	de completed)	(Give kind of wor	k done during mo	st of working	160.	KIND OF BU	SINESS/INO	USTRY			
2	12	College (1-4 or 5+)	Clerk				rocer					
8	17. FATHER'S NAME (First, Middle, Last)		CIEIR		16. MOTHER'S NA							
	Raymond James Hi	11 -			Olwen I		medio, mercen	Surrieme)				
H	19e. INFORMANT'S NAME (Type/Print)		19b, MAILING AI	ODRESS (Street o	nd Number or Rural		er Cltv or Tow	n Stata Zio	Codel			
임	George D. Cockre	11			Avenue,					d 20895		
	20e, METHOD OF DISPOSITION	201	PLACE AND DATE OF			OATE		CATION — (_			
	1 N Buriel 2 Cremetion 3 Red 4 Donation 8 Other (Specify)		ort Lincol	place)	terv 12	/8/95				aryland		
	21. SIGNATURE OF FUNERAL SERVICE L		1	22. NAME A	ND ADDRESS OF FA	CILITY						
	· Clearles	7. Beel			is Gasch					e, P.A. MD 20781		
	23. PART i. Enter the diseases, or	complications that cause	d the death. Do not	enter the mo	de of dying, suc	ch as Card	lsc or reapi	ratory sm	est,	Approximate		
	IMMEDIATE CAUSE (Final	List only ona cause on each line.							Interval Batween Onset and Death			
	disesse or condition											
- 1	DUE TO (OR AS A CONSEQUENCE OF):									3 0145		
z	METASTANC CARCINOMA 5005											
	Sequentially list conditions, If sny, leading to immediate DUE TO (OR AS A CONSEQUENCE OF):											
3	cause. Enter UNDERLYING CAUSE (Disesse or Injury	с	LUNG	CANCE	N							
HIFICATION	that initiated events resulting in death) LAST	DUE TO (OR AS A	CONSEQUENCE OF):									
CER		d,										
AL.	PART II. Other significant condition	ns contributing to death b	out not resulting in	the underlying	cause givan in	Pert I.	24s. WAS AN	AUTOPSY	24b.	WERE AUTOPSY FINDINGS		
EDIC							PERFOR			AVAILABLE PRIOR TO COMPLETION OF CAUSE		
						_	T YES 2 7NO OF		OF DEATH?			
5	DID TOBACCO USE CONT	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES X NO UNCERTAIN								T TES 2 NO		
¥	25. WAS CASE REFERRED TO MEDICAL		26. PLACE OF DEATH		- OTTORICITAL							
HYSICIAN: M	EXAMINER?	HOSPITAL: 1 Inpatient 2 ER/Outs		THER:	5 Pesidence	8 Other	(Specify)					
Ē	27. MANNER OF DEATH	28e. DATE OF INJURY	28b. TIME C	F 28c. INJ	URY AT			NJURY OCC	UREO			
1 Natural 5 Pending Investigation 2 Accident Investigation 3 Suicide 8 Could not be determined 4 Homicide determined Investigation 28e. PLACE OF INJURY — At home, ferm, atree1, fectory, office building, etc. (Specify) 28e. PLACE OF INJURY — At home, ferm, atree1, fectory, office City or Town, State)												
								nd Number	or Rurel Ro	oute Number,		
COMPLE	29e. CERTIFIER 1 CERTIFYING PHYS	BICIAN: To the bast of my know	ledge, death occurred	rt the time, date	end place, and due	to the cau	se(e) and man	ner es siste	d.			
5		ER: On the basis of examination								end menner se stated.		
	29b. SIGNATURE AND TITLE OF CERTIFIE				29c. LICENSE NU					Month, Day, Year)		
State a setución Dinasia								レノナ				
2	30. NAME AND ADDRESS OF PERSON W	HO COMPLETED CAUSE OF DE	ATH (ITEM 27) (Type, Pri	(nt)	DIL	۵۵ر		-		20902		
	Dr. Stanley Schwa	rtz, M.D. 210	l Medical	Park I	Orive, S	uite	201,	Silve	r Sp	ring, MD		
	31. DATE FILED (Month, Day, Year)	32. MEGISTRAR'S SIGN				-						
	DEC 8 1995	James and	St. Louis Co.									

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BALTIMORE, MARYLAND 21215-0020

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR STATE PEGISTRAR

	REGISTRAR		CENTIF	ICATE OF	DEALL	HEG.	NO.			
	1. DECEDENT'S NAME (First, Middle, Last)	NOEM	421	COHE	**	2. DATE OF DEAT	DAY 9	SYEAR 3. TIME OF DEATH		
	4. SOCIAL SECURITY NUMBER 5. SEX	8. AGE (In yrs	lest birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH		8. BIRTHPLACE (State or Foreign		
	141-22-9293 ¹₺	M2 DF	5 YRS.	MONTHS DAYE	HOURS MIN.	May 27,		New Jersey		
	9a. FACILITY NAME (If not institution, give street and)	Sh CITY TOWN	OR LOCATION OF DE			INTY OF DEATH			
or I	PE. PROBELLI TRAME (II TO INSTITUTO), give street and			9c. CO.	NIT OF BEATH					
0	Holy Cross Hospital	Silve	r Spring	M	ontgomery					
BY FUNERAL DIPECTOR	10a. STATE 10b. COUNTY		10c, CIT	Y. TOWN OR LOCA	TION	10d. INSIDE CITY				
	Maryland Prince Ge	Co	llege F			1 X YES 2 NO				
	5001 Indian Lane	16	20740		10g. CI1	U.S.A.				
	1 Never Married 2 Narried IF	ARMED	If yes, a	CENDENT OF HISPAN pecify Cuban, Mexicas B ZXXNO Specify	n, Puerto Rican, atc	14. RACE — American Indian, Black, Whita, atc. Specify: White				
0	15. DECEDENT'S EDUCATION	rean Confli	DECEDENT'S	USUAL OCCUPAT	ON	16b, KIND O	F BUSINESS/IN			
COMPLETED	(Specify only highest grade complete		(Give kind of ville. Do NOT us	work done during n se retired.)	ost of working					
2		ge (1-4 or 5+)	Ioma Co	onstruct	ion	Roof	1der			
2	12 Yrs	1	tome co	Justinci						
8	17. FATHER'S NAME (FIST, MIDDIN, LOST)					ME (First, Middle, Mi				
BE	Benjamin Cohen					Moskowit				
	19e, INFORMANT'S NAME (Type/Print)		196 MAILING	AODRESS (Street	and Number or Rural F	Route Number, City o	r Town, State, Z	(p Code)		
2	Jeanne A. Cohen	11.50	Co11a	no Park	Maryla	nd 2074	0			
	20s. METHOD OF DISPOSITION	20b. PLA		OF DISPOSITION (- City or Town, State		
	1 X Buriat 2 Cremation 3 Removal fro 4 Denation 5 Other (Specify)	m State cemetery	crematory or or	anon Cen	12/10	/1995	A 1 - 1 - 1-	t Manual and		
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE	Mour	it Leba				Adelph	i, Maryland		
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADORESS OF FACILITY STEIN HEBREW MEMORIAL FUNERAL HOME, INC. 23. CARROLL ST. NW. WASHINGTON, DC 20012									
TION	23. PART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or reapiretory arrest, abock, or heart fellure. List only one cause on each line. IMMEDIATE CAUSE (Finel disease or condition resulting in death) a. DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):									
CERTIFICATION	CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (OR AS A CO	NSEQUENCE O	F):		1				
	Darw II Cab as all selfices as addition and	alburate and all sale burate	-0							
EDICAL	PART II. Other aignificent conditions conf			in the underlyi	ng cause given in		S AN AUTOPSY RFORMED?	AMILABLE PRIOR TO		
200	Dusas	me clit			1 TES			COMPLETION OF CAUSE OF DEATH?		
	1+1P F	cactus:		1	X.	1 YES 2 NO				
2	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN									
A	25. WAS CASE REFERRED TO MEDICAL	26. F	LACE OF DEA	TH (Check only one						
0		PITAL:		OTHER:	1 -	EL COUNTY				
Ι¥S		npatient 2 ER/Outpatier			me 5 - Residence	,				
BY PHYSICIAN:	27. MANNER OF SEATH 1 Netural 5 Pending 2 Accident trivestigation	(Month, Day, Year)	28b. TIM	JURY W	UURY AT ORK? YES 2 NO	28d. DESCRIBE I	IOW INJURY O	CCURED		
ED		building, etc. (Specify)	At home, ferm,	street, factory, office 281. LOCATION (Street and Number or Rural Route Number, City or Town, State)						
COMPLET	29a. CERTIFIER (Check only One) 2 MEDICAL EXAMINER: On the best of my knowledge, death occurred at the time, data and placa, and dua to the cause(s) and manner as stated.									
BE	290. SIGNATURE OF TITLE OF CERTIFIER 290. LICENSE NUMBER 290. DATE SIONED (Month, Day, Year) 10690 12/7/95									
10	30. NAME AND ADDRESS OF PERSON WHO COM	PLETED CAUSE OF OEATH	(ITEM 27) (Type	751 (-9	7.7		(see	SPR My Lund		
	"DEC1 4"1995" Jilia	HE STATE OF A	E		-1116			Y		

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31. DATE FILED (Month, Day, Year)

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DEC 05 1995

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	Unre Turkers, unstance, as the buried risk permit. Pages 1, 2, 3 st. to recover, with the State between the buried-transit permit. Pages 1, 2, 3 st. be fled within 72 hours after the with the State between the best or Health and Mental Hygien prior to buried, cremation, or removal.	IMPORTANT: It lem 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.
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95 38375 FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH YEAR MARGARET Thelma CARRICO DECEMBER 1995 3:20 IF UNDER 1 YEAR IF UNDER 24 HRS.
MONTHS DAYS HOURS MIN. 4 SOCIAL SECURITY NUMBER 6. AGE (In yrs. lest birthday) 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreig Nov. 11,1905 1 🗌 M 2 🔯 F 90 Maryland 220-40-8848 YRS Se. FACILITY NAME (If not institution, give street and number 9b. CITY. TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH CITIZENS NURSING DIRECTOR HAVRE DE HOME GRACE HARFORD 10h COUNTY 10a STATE 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Harford Bel Air 1 YES 2 NO FUNERAL 10a. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 120 Glenwood Rd. 21014 United States 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No—If yee, specify Cuban, Mexican, Puerto Rican, etc.)

1 YES 2 X NO Specify: 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Merried BY 3 Widowed 4 □ Divorced Specify White COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY Elementery/Secondary (0-12) College (1-4 or 5+) Year Homemaker Home 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Meiden Surname) Dale Smith Sadie BE Margaret Hurley 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 A. Edward Snodgrass 120 Glenwood Rd. Bel Air, Md. 21014 20s. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION -- City or Town, State 208. METHOD OF DISPOSITION

1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State

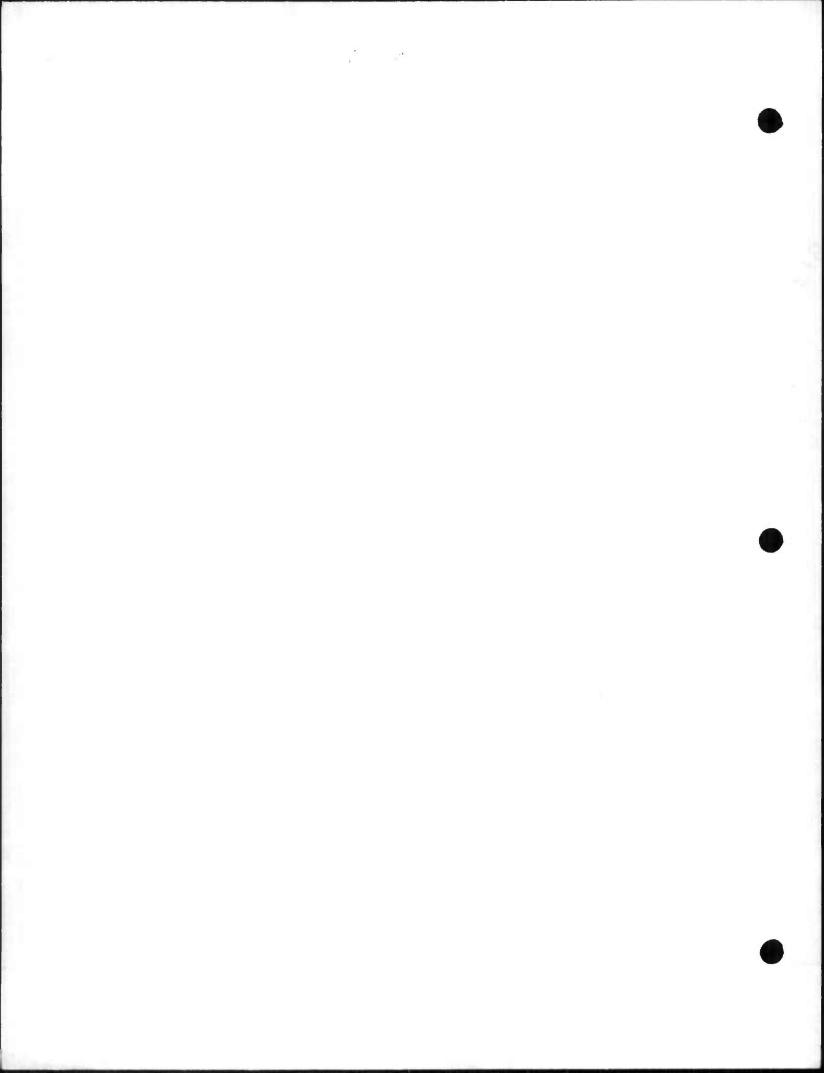
4 ☐ Donation 6 ☐ Other (Specify) R.A. Ferris & Co. Inc. 12-5-9 West Chester, Pa. 21. SIGNATURE OF FUNERAL SERVICE LICENSEE McComas Funeral Home 1317 Cokesbury Rd. Abingdon , Md. 21009 23. PART i. Enter the diseases, or complications that caused the deeth. Do not anter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betwe IMMEDIATE CAUSE (Final Onset and Death disease or condition 1/1Eculostiff resulting in death) DUE TO (OR AS A CONSEDUENCE OF) CERTIFICATION Sequentially list conditions, if any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF): cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF)that initiated events resulting in death) LAST PART, II. Other algnificant conditions contributing to deeth but not resulting in the underlying ceuse given in Part I. 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 24a. WAS AN AUTOPSY PERFORMED? MEDICAL CONSTINE HERET FAILURE - 49/0A8/aD. 1 TYES 2 NO DE DEATHS CEKESBIL LAS CUSIK 1 YES NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATH (Check only one) HOSPITAL: Nursing Home 6 Residence 6 Other (Specify) 1 TES 2 ND 1 Inpatient 2 ER/Outpatient 3 DOA 27. MANNER OF DEATH 26e. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT 28d, DESCRIBE HOW INJURY OCCURED Natural 5 Pending BY 1 YES 2 ND Investigation Aboldent 26e. PLACE OF INJURY — At home, ferm, street, factory, office building, etc. (Specify) 3 Suicide 261. LOCATION (Street and Number or Rural Route Number, City or Town, State) 6 Could not be ETED. 4 Homicide determined 29e. CERTIFIER CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(e) end manner ee stated. COMPL (Check only one) 2 MEDICAL EXAMINER: On the basic of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(e) and manner ee stated. 296. SIGNATURE AND TITLE OF CENTRIES BE 29c. LICENSE NUMBER 29d. DATE SIGNED (Month

WHD COMPLETED CAUSE DF DEATH (ITEM 27) (Type, Print)

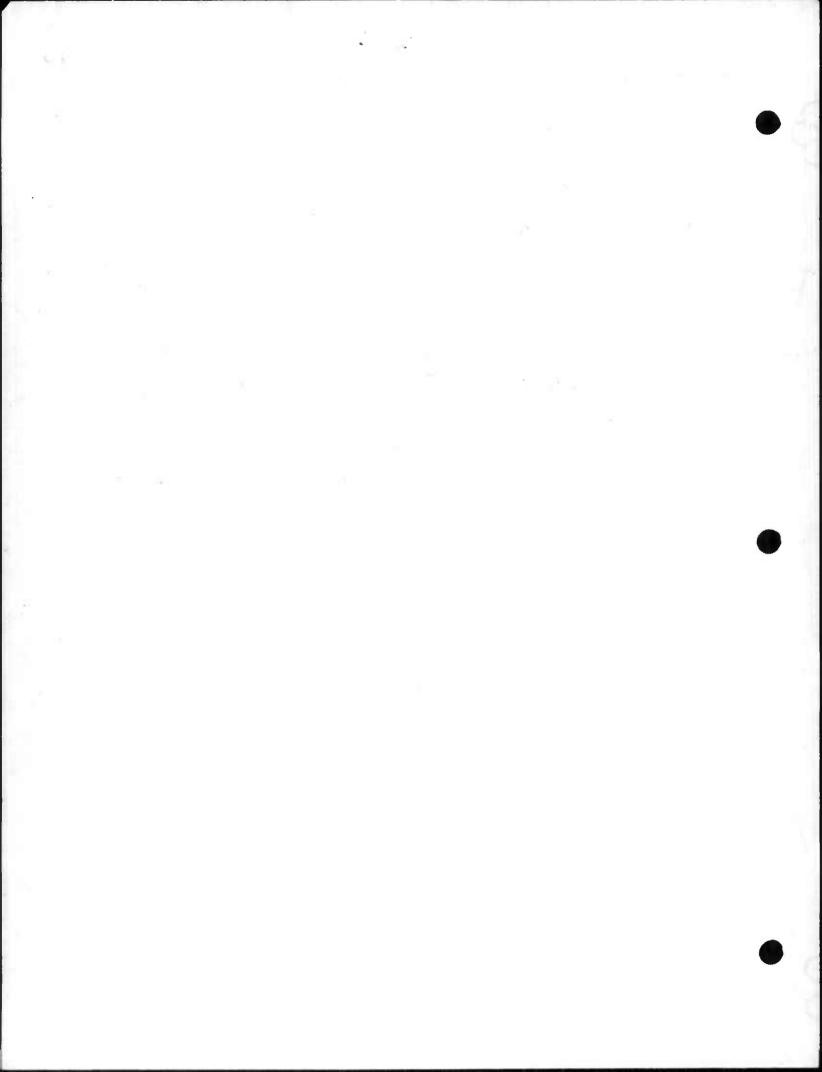
32. APOISTRAR'S SIGNATURE Partall

SILATON

DHMH-16 Rev 1/89



	_	1 - FOR STATE REGISTRAR	STATE OF MARYL		RTMENT OF H		MENTAL	HYGIENE REG. NO.			
		1. DECEDENT'S NAME (First, Middle, Last)	yda Ar		spell	a	2. DATE (12 DAY 03	YEAR 95	3. TIME OF OEATH / 45A M	
P		220-09-3394	1 🗆 M 2 💢 F	n yrs. lest birthday) 85 YRS.	# UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	12-	Day, Year) 20-1909	8. BIRTHE Country	PLACE (State or Foreign) MD	
, 2, 3 should	стов	9a. FACILITY NAME (If not institution, give street and number) Calvert Manor Nursing Home Calvert									
f. Pages 1.	DIREC	10a. STATE 10b. COUNTY	larford	10c. CIT	Y, TOWN OR LOCAT	re de Gr	ace			10d. INSIDE CITY LIMITS? 1 X YES 2 NO	
nsit permit.	ERAL	10e. STREET AND NUMBER 414 Bourbon St	treet			1. ZIP COOE 21078		10g. CI		HAT COUNTRY?	
ALTIMORE, MARYLAND 21215-0020 death. Page 6 may be retained by the hospital or attending physician. funeral director, page 5 should be detached for use as the burial-transit examiner must be notified at once.	BY FUN	11. MARITAL STATUS 1 Never Merried 2 Married 3 X Widowed 4 Olivorced 12. WAS OCCEDENT EVER IN U.S. FORCES? 1 VES 2 IF YES, GIVE WAR OR DATES			If yes, sp	CENDENT OF HISPAN ecify Cuben, Maxica i 2 NO Specify	n, Puerto R	(Specify Yea or No-	- 14. RACE — American Indian, Black, White, etc. Specify: White		
21215-0 al or attending for use as the	LETED	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5 +)			USUAL OCCUPATION work done during mose retired.)	ON sst of working	16b.	KIND OF BUSINESS/IN	IOUSTRY	- Wille	
The hospital detached to once.		9 17. FATHER'S NAME (First, Mickelle, Lest)			omemake		ME (First, M	Hor			
retained by 5 should be notified at	1 111	Ernest (19b. MAILING	ADDRESS (Street e		Mary Hackney nber or Rural Route Number, City or Town, State, Zip Code)					
RE, M lay be re page 5:	٦	Mrs. Patricia Fair	20b.		oncord I		avre	de Grace			
ALTIMORE, death. Page 6 may be numeral director, page i. examiner must be 1		1X Burlal 2 Gremation 3 Removal from State 4 Donation 5 Other (Specify) Angel Hill Cemetery 12/6 Havre de Grace, MD 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY									
~ - 2 =	- 1	Mitchell-Smith Funeral Home, P.A. Havre de Grace, MD 21078-3197									
within 24 hours at mpletely filled in by cremation, or removed.		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or reapiratory errest, abook, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) Due TO (OR AS A CONSEQUENCE OF):									
P.O. BOX 687 h certificate be execute ending physician and or l Hygiene prior to buria or other traumatic	CERTIFICATION	Sequentially list conditions, if any, laading to immediata cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF):									
CORD ires that the signed by the fealth and M		PART II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 1 VES 2 NO 1 VES 2								WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?	
has the	AN	DID TOBACCO USE CONTRI		DEATH YE		UNCERTAIN	V 🗆			1 YES 2 NO	
E # # E	PHYSICI	EXAMINER?	IOSPITAL:		OTHER:	e 5 🗆 Realdence	6 🗌 Other	(Specify)			
NG PHYSIC fler this ce sath with ti	ВУ РН	27. MANNER OF DEATH 1 Netural 5 Pending 2 Accident Investigation	28a. OATE OF INJURY (Month, Day, Year)	28b. TIM INJ	URY WO	URY AT PRK7 YES 2 NO	28d. OE\$C	O YRULNI WOH BBIRS	CURED		
TTENOI TOR: A after de	8	3 Suicide 6 Could not be determined 28e. PLACE OF INJURY — At home, lerm, street, factory, office building, etc. (Specify) 28e. PLACE OF INJURY — At home, lerm, street, factory, office City or Town, State) 281. LOCATION (Street and Number or Bural Route Number, City or Town, State)							ute Number,		
3 7 Z E	COMPLET		AN: To the best of my knowle On the basis of examination							and menner as stated.	
TO THE HOSPITAL TO THE FUNERAL De filed within 72 IMPORTANT: If	8	296. SIGNATURE AND TITLE OF CERTIFIER		00)		29c. LICENSE NUM		29d. DA	TE SIGNEO	Month, Day, Year)	
	TO	30. NAME AND ADDRESS OF PERSON WHO	or MO	Rian	6	7. Mc	olum.	ind 210	31)		
		31. DATE FILEO PAPELL, CON 1005 1995	32. REGISTRATES SIGNA JULIA D'AUCLE	TURE Rardall	0	,			-		



FOR

1 - REGISTRAR		CER	TIFIC	ATE O	F DEATH		REG. NO.				
1. DECEDENT'S NAME (First, Middle, Last)						2. DATE OF DEATH MONTH DAY YEAR 3. TIME OF DEATH					
DO	KE			Dec		1995		1235 P			
4. SOCIAL SECURITY NUMBER	5. SEX 6. A	GE (In yrs. lest bir		F UNDER 1 YEAF	7	7. DAT	E OF BIRTH		8. BIRTH	IPLACE (State or Foreign	
219-30-5472 9a. FACILITY NAME (If not institution, give si	1 M 2XXF	60	YRS.	DAYS DAYS	HOURS MIN.		1. 8,19		Mar	yland	
	8601 Castlemill Circle					DEATH			timo		
10a. STATE 10b. COUNTY										10d. INSIDE CITY LIMITS?	
Maryland Balt:	imore		Balt	imore						1 TES 2XX NO	
100. STREET AND NUMBER 8601 Castlemill C: 11. MARITAL STATUS 1 \(\sum \) Never Married 2 \$\frac{1}{2}\$ Warried	100. STREET AND NUMBER 8601 Castlemill Circle									what country? States	
11. MARITAL STATUS 1 Never Merried 2 X Merried 3 Widowed 4 Divorced	1 Never Married 2 Married FORCES? 1 YES				ECENDENT OF HISP specify Cuben, Mexi ES 2X NO Spec	cen, Puerto		s or No-	14. RACI Blac Spec Whi		
18. DECEDENT'S EDU	18. DECEDENT'S EDUCATION			UAL OCCUPA	TION most of working	16	Sb. KIND OF BU	DUSTRY	UNALL		
18. DECEDENT'S EDU (Specily only highest grade Elementary/Secondary (0-12) 1. FATHER'S NAME (First, Middle, Lest)				etired.)	most of working	I	Law Off	ice			
17. FATHER'S NAME (First, Middle, Last)					18. MOTHER'S	AME (First	, Middle, Maiden	Surname)			
	tt Pearc	e			Doroth	y I	Harriet	D	raeg	er	
19a. INFORMANT'S NAME (Type/Print)		19b. N	IAILINO AI	DDRESS (Sire	et and Number or Run	il Floute Nu	mber, City or Tow	rn, State, Zi	p Code)		
John A. Clarke		860	01 Ca	stlem	ill Circ	le Ba	altimor	e ,	Md.	21236	
20a. METHOD OF DISPOSITION	ougl from State				POSITION (Name of OATE 20c. LOCATION — City or Town						
4 Donation 5 Other (Specify)	1 Burial 2XXCremetion 3 Removal from State Commetery, crematory or other place) R.A. Ferris & Co. Inc. 12+5-95 West Chester,									r,Pa.	
22. NAME AND ADDRESS OF FACILITY McComas Funeral Home 1317 Cokesbury Rd. Abingdon, Md. 2100											
Sequentially list conditions, if any, isading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initieted events resulting in death) LAST	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):										
	d		J 7 7 P	7-64							
PERFORMED? 1 VES 2 NO OF									b. WERE AUTOPSY FINDING AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO		
25. WAS CASE REFERRED TO MEDICAL		26. PLACE	OF DEATH	(Check only o	ne)						
1 YES 2 TO	EXAMINER? 1 YES 2 TO 1 Inpetient 2 ER/Oulpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify)										
DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 TO 27. MANNER OF DEATH 1 Netural 5 Pending	17. MANNER OF DEATH 1 Matural 5 Pending 28e. DATE OF INJURY (Month, Day, Year)				INJURY AT WORK?	28d. D	28d. DESCRIBE HOW INJURY OCCURED				
2 Accident Investigation 3 Suicide 8 Could not be 4 Homicide determined	28a. PLACE OF IN- building, etc.		Y — At home, farm, street, factory, office 2:			28f. La	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				
and the same of th	ER: On the beet of exemi									(s) and manner as stated.	
296 SIGNATURE AND TITLE OF RENTIFIE	196 GIGNATURE AND TITLE OF GERTIFIER OF SILLIAM OF					IUMBER		29d. DA	TE SIGNE	9 (Month, Day, Year) 5 9 5	
30. NAME AND ADDRESS OF PERSON WIN	40 COMPLETED CAUSE O	FOEATH (ITEM :	O DE	FA BO			JUSEP	4'5	TO	wson M	
DEC 06 1995 July Day, Your DEC 06 1995 July Decigor Decidor De											

HOSPITAL

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AAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the by		0000
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FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH 3. TIME OF DEATH YEAR Grace Christy Dec 1995 47P 7. DATE OF BIRTH 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR 8. BIRTHPLACE (State or Foreign Country) IF UNDER 24 HRS 55 54 YAS. 220-40-8199 1 M 2 XF DAYS HOURS IISA 9s. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR ER Harford memorial Hospital Havre De Grace Harford RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MD Harford Aberdeen 1 YES 2 NO FUNERAL 10e. STREET AND NUMBER 101, ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 139 Hanover Street 21001 USA 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-If yea, specify Cuben, Mexican, Puerto Rican, etc.) 14. RACE — American Indian, Black, White, etc. 1 Naver Married 2 Married ВУ 1 YES 2 NO Specify: Specify: Black 3 Widowed 4 Divorced COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 166. KIND OF BUSINESS/INDUSTRY (Specify only highest grade comp Elementary/Secondary (0-12) College (1-4 or 5 +) Homemakek 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maide Alter BE INFORMANT'S NAME (Type/Print) 2 RAINE TaNover METHOD OF DISPOSITION 206. PLACE AND DATE OF DISPOSITION / DATE 1 Mariel 2 Cremation 3 Ren
4 Donation 5 Other (Specify) Len race. 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, Approximate ahock, or heert fellure. List only one cause on each line. intervsi Between IMMEDIATE CAUSE (Fine) Onset and Death disease or condition_ Acute Coronary Artery Disease resulting in death) DUE TO (OR AS A CONSEQUENCE OF): ASCVD CERTIFICATION Sequentielly list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Diseese or Injury DUE TO (OR AS A CONSEQUENCE OF) thet initiated eventa resulting in deeth) LAST PART il. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE 24e. WAS AN AUTOPSY PERFORMED? MEDICAL Hypertension 1 TYES 2 NO OF DEATH? 1 TYES 2 THO DID TOBACCO USE PHYSICIAN: OF DEATH CONTRIBUTE TO CAUSE 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATH (Check only one. HOSPITAL:
1 | Inpatient 2 | XER/Outpatient 3 | DOA OTHER: 1 X YES 2 NO 4 - Nursing Home 5 - Residence 6 - Other (Specify) 28a. DATE OF INJURY (Month, Day, Year) 27. MANNER OF DEATH 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED XXNetural 5 Pending м 1 YES 2 TONO ВУ NA NA 2 Accident PLACE OF INJURY — At home, term, street, fectory, office building, atc. (Specify) 3 Suicide ETED . 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 4 Homicide datarmined NA NA COMPL 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated. 2 XMEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(s) and manner as stated. TO THE HOSPIT TO THE FUNERS be filed within I 29b. SIGNATURE AND TITLE OF CERTIFIER BE 29c. LICENSE NUMBER 29d, DATE SIGNED (Month, Day, Year) D21809 DME 2-5-1995 2

1810BELAIR RD #012 FALLSTON MD. 21047 410879-6564

Legistran's Signature 1995

30. NAME AND ADDRESS OF PERSON WNO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

G.S.PRABHU M.D.

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within — nours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burlal-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burlal, cremation, or removal.

IMPORTANT: If them 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

FOR STATE

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	* REGISTRAR		CERTIFI	CALE	F DEA	111		REG. NO.			
	1. DECEDENT'S NAME (First, Middle, Lust)		Chapman				MONTH	2. DATE OF DEATH DAY YEAR DEC 6 95			6:14 PM
TOR	Catherine 4. SOCIAL SECURITY NUMBER 212-40-8501 1 -	8. AGE (III	yrs. last birtnday) YRS.	IF UNDER 1 YEAR	_	24 HRS. MIN.	7. DATE 0 (Month, Sept	Day, Year)	909	Country)	ACE (State or Foreign the Caroli
		9a. FACILITY NAME (If not institution, give street and number) Memorial Hospital					9b. CITY, TOWN OR LOCATION OF DEATH Easton Be. COUNTY OF DEATH Talbot				
FUNERAL DIRECTOR	10a, STATE 10b, COUNTY	1bot	10c. CITY	LIMI						d. INSIDE CITY LIMITS? X YES 2 \(\text{NO} \)	
ERAL	100. STREET AND NUMBER 8528 Blackdog Al	ley			10f. ZIP COD	1601		10g. CITIZEN OF WHA			
BY FUN	1 News Married 2 Married FO	S DECEDENT EVER IN RCES? 1 YES YES, GIVE WAR OR DA	2 XNO	If yes,	DECENDENT (specify Cube (ES 2 X NO	n, Mexica	in, Puerto Ri	(Specify Yes loan, atc.)	or No	Black, V	American Indian, thite, etc.
COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade complete Elementary/Secondary (0-12) Colle	ed) ge (1-4 or 5 +)	(Give kind of w life. Do NOT use	is. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working like. Do NOT use retired.) Laborer Domestic							
	17. FATHER'S NAME (First, Middle, Last) Zachari Johnso	n				HER'S NA		ddle Melden	Surname)		
) BE	19e. INFORMANT'S NAME (Type/Print)			ADDRESS (Stre	et end Numbe	r or Rural	Route Numbe	er, City or Town			
5	Mary LIza Dawson			Plac		A11			_		
	20e. METHOD OF DISPOSITION 1 Burlei 2 Cremation 3 Removal fro 4 Donellon 5 Other (Specify)		PLACE AND DATE OF DISPOSITION (Name of large, cremetory, or other place) LEEN Esther Ceme. 12/9 Easton, Md							, suna	
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE Williamson-Fluharty Funeral service 1319 E. Dover st.Easton, Md. 21601										
CERTIFICATION	IMMEDIATE CAUSE (Final disease or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):										
	that initiated events resulting in deeth) LAST d. PART II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY PREFORMED? AMILIABLE PRIOR TO AMILIABLE PRIOR TO										
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PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL: OTHER:										
	27. MANNER OF DEATH 1 Whatural 5 Pending	28b. TIM	4 Nursing Home 5 Residence 8 Other (Specify)								
TED BY	2 Accident investigation 3 Suicide 8 Could not be determined 28e. PLACE OF INJURY — At home, farm, atreet, factory, office building, atc. (Specify) 28e. PLACE OF INJURY — At home, farm, atreet, factory, office building, atc. (Specify) 28e. PLACE OF INJURY — At home, farm, atreet, factory, office building, atc. (Specify)								r or Aural Rou	ite Number,	
COMPLETED	29e. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) end manner se stated. 2 MEDICAL EXAMINER: On the best of examination end/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(e) end manner se stated.										
TO BE C	29b. SIGNATURI AND TYPLE OF CERTIFIED 29c. LICENSE NUMBER 20d. DATE SIGNED (Month, Day, Year) D 447 49 12/7/95										
	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Peter Whitesell, M.D. 609 -B Dutchmans Lane Easton, Md. 21601 31. Date Filed (Month, Day, Year) 32. REGISTRAR'S SIGNATURE										
	31. DATE FILED (Month, Day, Year) DFC 0.8 1995	Taba Davides	Rardalle								

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DIVISION OF VITAL RECORDS, P.O. BOX 6876

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TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with hours after death. Page 6 may be retained by the	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detained within 72 hours after death with the State Devi of Health and Mental Horiene orior to build, committed or removal.	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at on
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FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO 3. TIME OF DEATH OS 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH BANCIS P. COENE 9 Dec DM 994 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In vrs. lest birthdev IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign Nov. 12, HOURS Illinois 342-20-2814 1 XX 2 - F 84 1911 9a. FACILITY NAME (If not institution, give street and numb 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH Suburban Hospital Bethesda DIRECTOR Montgomery RESIDENCE OF DECEDENT 10d. INSIDE CITY
LIMITS?
1. WES 2 NO 10a. STATE 10b. COUNTY INC. CITY TOWN OR LOCATION Illinois Rock Island Moline 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 1401 Third Street 61265 U.S.A. 11. MARITAL STATUS 12. WAS DECEDENT EYER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, White, atc. 1 Never Married 2 Merried If yes, specify Cuban, Maxican, Puerto Rican, etc.)

1 YES 2 NO Specify: Specify white BY 3 Widowed 4 Divorced tee. DECEDENT'S USUAL OCCUPATION COMPLETED 15. DECEDENT'S EDUCATION teb. KIND OF BUSINESS/INDUSTRY (Specify only hig (Give kind of work done life. Do NOT use retired.) Grade 9 College (1-4 or 5+) owner/operator plumbing 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) August Coene Louise Rumbout BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILINO ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Margaret Coene 1401 Third Street Moline, Illinois 61265 20a. METHOD OF DISPOSITION t D Burial 2 Cremation 3 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State 1277 St. Mary s Cemetery East Moline, Illinois 4 Donation 5 Other (Specify) 95 21. SIGNATURE OF FUNERAL MUNICIPAL LICENSEE 22. NAME AND ADDRESS OF FACILITY
Donaldson Funeral Home P.A. aug 313 Talbott Avenue Laurel, Md. 20707 23. PART I. Enter the diseases, or complice shock, or heart failure. List oni tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximata intervel Between Onset and Death one ceuse on eech line. IMMEDIATE CAUSE (Finei disease or condition aura resulting in death) CONSEQUENCE OF CERTIFICATION Sequentially list conditions, if sny, leading to immediate cause. Enter UNDERLYING CAUSE (Disesse or Injury DUE TO (OR AS A CONSEQUENCE OF) that initiated evente resulting in deeth) LAST PART II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Part I. 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS MEDICAL PERFORMED? AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 TES 2 NO My ocardid Tafacta 1 | YES 2 | NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \(\Boxed{1}\) NO \(\Boxed{1}\) UNCERTAIN \(\Boxed{1}\) PHYSICIAN: 28. PLACE OF DEATH (Check only one) 25. WAS CASE REFERRED TO MEDICAL HOSPITAL:
1) Inpatient 2 ER/Outpatient 3 DOA I YES 2 NO 4 Nursing Home 5 Residence 6 Other (Specify) 27. MANNER OF GEATH 28a. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 28b. TIME OF INJURY 2ed. OESCRIBE HOW INJURY OCCUREO 1 Netural 5 Pending м В Investigation 2 Accident 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. PLACE OF INJURY — At home, ferm, street, factory, office building, etc. (Specify) 6 Could not be determined COMPLETED 29a. CERTIFIER
(Check only one)

29 MEDICAL EVAMINES: On the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On the basis of exa Investigation, in my opinion, death occured at the time, data and place, and due to the cause(a) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIES BE MD 0 960 ne 2

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Roma 31. DATE FILEO (Month, Day, Year) 32. REGISTRAR'S SIGNATURE DEC 06 1995 Sheider Ra

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type,

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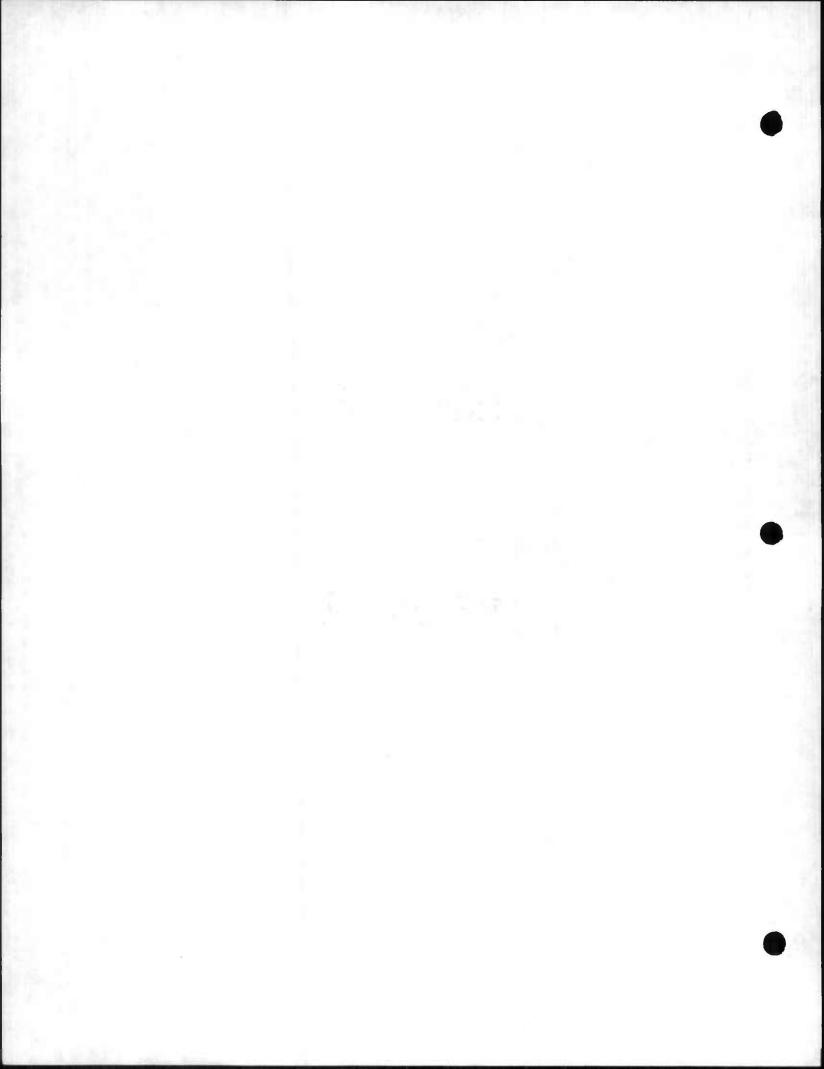
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		FOR STATE REGISTRAR		STATE OF MA				HEALTH AND I	MENTAI	L HYGIEN	E		
	:	1. OECEDENT'S NAME (First,		E.		Do	lW50n		2. DATE MONTH Dece		**	YEAR 995	3. TIME OF DEATH
P		4. SOCIAL SECURITY NUMBER 220-10-07	55	M 2 F	AGE (In yrs.	YRS.	IF UNDER 1 YEAR	IF UNDER 24 HRS. HOURS MIN.	JUN	OF BIRTH 1, Day, Year) E 4,1		MA	RYLAND
, 2, 3 should	CTOR	9a. FACILITY NAME (If not institution, give street and number) SHADY GROVE ADVENTIST HOSPITAL ROCKVILLE MONTGOMERY RESIDENCE OF DECEDENT											
Pages	DIREC	MD .	10b. COUNTY	SOMERY			TOWN OR LOCA	TION ERSBURG					10d. INSIDE CITY LIMITS? XX YES 2 \(\text{NO} \) NO
pryskkan. burial-transit permit.	ERAL	100. STREET AND NUMBER 401 RU		AVE. #7	13			01. ZIP CODE 2087	 7		10g. CITI	U.S	HAT COUNTRY?
the it	BY FUN	11. MARITAL STATUS 1 Never Married 2 1 3 Wildowed 4 Divor		2. WAS DECEDENT F FORCES? 1 X IF YES, GIVE WAR WWII	VER IN U.S. YES 2 OR DATES	ARMED NO	If yes, s	CENDENT OF HISPAN pecify Cuban, Maxica S 2 NO Specify	in, Puerlo f		or No-	14. RACE	— American Indian, White, etc.
of for use as	PLETED		DENT'S EDUCAT highest grade co.	mpleted) College (1-4 or 5+)	1	Give kind of wo		ION lost of working	16b.	KIND OF BUS			
be detached at once.	E COMPL	17. FATHER'S NAME (First, Middle, Lest) GEORGE ZEA DAWSON					GEK_	18. MOTHER'S NA	ME (First, I	Middle, Maiden	S.D. Surname) PRIT		RD
page 5 should be notified	TO B	19a. INFORMANT'S NAME (Ty RANDALL	pe/Print) L.	SCOTT		195. MAILING A 6411		and Number or Rural					. 20770
director, pa		20a. METHOD OF DISPOSITION 1	Specify)		cemetery, o	E AND OATE OF crematory or othe MBERS	CREMA	ATORY]	12/6		IVEF		
the funeral director, the funeral director, oval.		21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY SILVER SPRING, MD. W. W. CHAMBERS CO. INC. 20910 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory strest, Approximate											
rent, the		23. PART I. Enter the disock, or he immEDIATE CAUSE (Findisease or condition resulting in death)	ert fallure. Lis al	Run to DUE TO (OF	on each li	ne.				flac or respi	ratory sm	est,	Approximats Interval Between Onast and Death 24 hrs
ending physician and Hygiene prior to bur or other traumatic	CERTIFICATION	Sequentially list condition if any, leeding to immade cause. Enter UNDERLYII CAUSE (Disease or injurthat initiated events resulting in death) LAST	elate NG c.			SEQUENCE OF):							
The state of	MEDICAL C	PART II. Other algnificer	conditions	t resulting in	the underlyli	ng ceuse given in	Part I.	PERFORMED?		24b.	24b. WERE AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO		
cate has bee State Dept o Item 23 sh	SICIAN:	DID TOBACCO US 25. WAS CASE REFERRED TO EXAMINER?	MEDICAL	BUTE TO CAUS		ACE OF DEATH	(Check only one	UNCERTAI	N 🔲				
fer this certifical seth with the St marked, or N	₽Ħ		Pending	Inpatient 2 Et	JURY		OF 28c. IN	IJURY AT		r (Specify) SCRIBE HOW I	NJURY OCC	CURED	
DIRECTOR: After the hours after death vision after death vision after death vision and the hours after death vision and the hours after death vision and the hours after death vision and the hours after the	тер ву	1 Naturel 5 Pending Investigation										loute Number,	
VERAL DIRECTION TO THE TANK TO THE TANK TO THE TANK THE T	COMPLET	one) —		AN: To the best of my									and manner as stated.
TO THE FUNERY TO THE FUNERY De filed within 7	TO BE C	29b. SIGNATURE AND TITLE. 30. NAME AND ADDRESS OF	and	COMPLETED CAUSE	VV-	S (From 1	mD	29c. LICENSE NUI					(Month, Day, Year) BBF 4 1995
		James R. 31. DATE FILED (Month, Day, J	noor	32, REGISTRAR'S	20 SIGNATURE	7 Br	ookes	Ave G	aith	ers bu	rg h	np.	ber 4 1995 20877
L		DEC OF	1995	Jalia Dave	dear Ro	relati							OHMH-16 Rev t/8

TO BE COMPLETED BY FUNERAL DIRECTOR

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hosp	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached	ithin 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial. cremation, or removal.	IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.
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FOR STATE REGISTRAR	STATE OF MARY			HEALTH AND I	MENTAL HYGIE REG. N					
1. DECEDENT'S NAME (First, Middle, Eleanor B.					2. DATE OF DEATH MONTH November	^{DAY} 28,		TIME OF DEATH 1:10P.M		
4. SOCIAL SECURITY NUMBER 201-12-6936	1 M 2 XF 7	iE (in yrs. lest birthday) O YRS.	MONTHS DAY	Penr	8. BIRTHPLACE (State or Foreign Country) Pennsylvania					
9e. FACILITY NAME (If not institution, Mediplex of Mon	tgomery Villa	ge	-	n or Location of DE thersburg	ATH		Montg			
Mediplex of Mon RESIDENCE OF DECEDEN 100. STATE 100. STATE 100. STATE	DUNTY		TY, TOWN OR LO					10d. INSIDE CITY LIMITS?		
	Montgomery	G	aithers	101. ZIP CODE			TIZEN OF WH	1 X YES 2 NO		
10e. STREET AND NUMBER 768 Tiffany 11. MARITAL STATUS 1 Never Married 2 Married 3 🗶 Widowed 4 Divorced	12. WAS DECEDENT EVE FORCES? 1 YE IF YES, GIVE WAR OF	ES 2 X NO	If yes,	20878 DECENDENT OF HISPAN Specify Cuban, Mexica ES 2 X NO Specify	n, Puerto Rican, etc.)		14. RACE -	American Indian, White, atc. White		
15. DECEDENT'S (Specify only highest Elementary/Secondary (0-12) 17. FATHER'S NAME (First, Middle, Le.)		(Give kind of			166. KIND OF E		Mach			
Joseph R. R	ice			18. MOTHER'S NA Caroly	ME (First, Middle, Meid one M. Duc	las				
Susan J. Wogats	ske	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11000 Brink Road, Germantown, Maryland 20876 20b. PLACE AND DATE OF DISPOSITION (Name of Language Control of City or Town, State)								
4 Donation 5 Other (Specify,	1 X Burial 2 Cremetion 3 Removal from State Commettery or other place December 2, 1995 Gate of Heaven Cemetery Silver Spring 21. SIGNATURE OF FUNERAL SERVICE LICENSEE M00831 22. NAME AND ADDRESS OF FACILITY Robert A. Pumphrey Funeral Home/									
iMMEDIATE CAUSE (Finel disease or condition resulting in death)	a. Small cell DUE TO (OR A	n each line.	oma of				rrest,	Approximate interval Batween Onest and Deeth 2-3 month		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in deeth) LAST	E (Disease or injury oue to (OR AS A CONSEQUENCE OF):									
PART II. Other eignificent con Central Nervo degeneration,	us System dise COPD, HBP, Atri ONTRIBUTE TO CAUSE	Cerebellum lation, Malnutrition S NO UNCERTAIN					WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO			
EXAMINER? 1 YES 2 X NO										
2 Accident investig	1 X Natural 5 Pending 2 Accident Investigation				M 1 YES 2 NO					
4 Homicide determine	AL APPRIESO									
(Check only one) 2 MEDICAL EX	AMINER: On the basis of examina			n, death occured at the	time, data and place,	the cause(s) and manner as stated. The, data and place, and due to the cause(s)				
MANE AND ADDRESS OF PERSO	Sara MD	DEATH (ITEM 27) (To	D10493 29d. Date signed (Month, Day, Year) November 28,1							
	I.D., 809 Veir	s Mill Ro		kville, M	aryland 2	.0851-	1689			
DEC 04		dear Rendal								

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retained by the hospital or attending physician BALTIMORE, MARYLAND 21215-0020 6 may be

FOR STATE REGISTRAR

RONALD

1. DECEDENT'S NAME (First, Middle, Last)

4. SOCIAL SECURITY NUMBER

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6. AGE (In yrs. last birthday)

5. SEX

DIVISION OF VITAL RECORDS, P.O. BOX 68760

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7. DATE OF BIRTH (Month, Day, Year) 1 🔯 M 2 🗌 F YRS. 186-26-4009 60 July 12, 1935 Pages 1, 2, 3 should Sa. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH DIRECTOR THE JOHNS HOPKINS HOSPITAL BALTIMORE CITY 10b. COUNTY 10a. STATE 10c. CITY, TOWN OR LOCATION Maryland Montgomery Gaithersburg permit. 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE 19104 Roman Way 20879 burial-transit 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-II yes, specify Cuban, Maxican, Puerio Rican, atc.) FORCES? 1 YES 2 1 Never Married 2 Married 1 YES 2 NO Specify: BY 3 Widowed 4 Divorced use as the COMPLETED 18a, DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION (Specify only I 10 College (1-4 or 5+) Elementary/Secondary (0-12) 5+ Senior Engineer I.B.M. once. 17. FATHER'S NAME (First, Middle, Lest) 18. MOTHER'S NAME (First, Middle, Maiden Surname) 2 Ħ Robert B. Duty Evelyn M. Ryan BE pinous notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Phyllis Mae Duty 19104 Roman Way, Gaithersburg, Maryland director, page 5 pe 20a. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of cemetary, crematory or other place) December 9, Parklawn Memorial Park 20s. METHOD OF DISPOSITION

1 Of Buriel 2 Cremetion 3 Removal from State

4 Donation 6 Other (Specify) must 1995 22. NAME AND ADDRESS OF FACILITY Robert A. Pumphrey Funeral Home/Rockville, Inc., 300 W. Montgomery Ave Rockville, Maryland 20850-2805 examiner SIGNATURE OF FUNERAL SERVICE LICENSEE M00348 Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. medical 23. PART I. Enter the diseases, or cor IMMEDIATE CAUSE (Finel cremation. the disease or condition_ RESPIRATORY FAILURF resulting in death) event, DUE TO (OR AS A CONSEQUENCE OF): and com PANCREATIC traumatic CANCER CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate cause. Enter UNDERLYING inding physician Hygiene prior to LIVER CIRRHOSIS CAUSE (Disease or Injury other DUE TO (OR AS A CONSEQUENCE OF) that initiated events resulting in death) LAST 0 Wental ! injury, PART II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY PERFORMED? MEDICAL 30 апу signed Health a 1 YES 2 NO shows been of DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: has be Dept. 23 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one HOSPITAL:
1 | Impetient 2 | ER/Outpetient 3 | DOA OTHER: 1 YES 2 NO 4 Nursing Home 5 Residence 6 Other (Specify) the S 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 28c. INJURY AT WORK? 26d, DESCRIBE HOW INJURY OCCURED marked, this 1 Natural 5 Pending 1 YES 2 NO BY 2 Accident
3 Suicide Investigation After 28a. PLACE OF INJURY — At home, farm, street, factory, offica building, atc. (Specify) .09 6 Could not be COMPLETED DIRECTOR: 4 Homicide 28 Hem 29a. CERTIFIER

(Chack only

CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and menner as stated. TO THE HOSPITAL TO THE FUNERAL ID TO THE FUNERAL ID TO THE FUNERAL IF IN IMPORTANT: If IN (Check only one) 2 MEDICAL EXAMINER: On the basic of exemination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(s) and manner as stated. 29h SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER BE N2488 MP 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) CHAN M.D 600 NORTH WOLFE STREET 31. DATE FILED (Month, Day, Year) 32, REGISTRAR'S SIGNATURE

Sancter Revolate

08 1995

CERTIFICATE OF DEATH

IF UNDER 1 YEAR

IF UNDER 24 HRS.

2. DATE OF DEATH

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REG. NO 3. TIME OF DEATH YEAR DECEMBER 5,1995 4:50 Рм 8. BIRTHPLACE (State or Foreign Country) Pennsylvania 9c. COUNTY OF DEATH None 10d. INSIDE CITY 1 TYES 2 XNO 10g. CITIZEN OF WHAT COUNTRY? United States 14. RACE — American Indian, Black, White, etc. Specify. White 16b. KIND OF BUSINESS/INDUSTRY 20879 20c. LOCATION - City or Town, State Rockville, Maryland Approximate Interval Between Onset and Death 4 HOURS 6 months 6 months 24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 TYES 2 NO 281, LOCATION (Street and Number or Rural Route Number, City or Town, State) 29d. DATE SIGNED (Month, Day, Year) December 5,1995

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1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

\neg	1. DECEDENT'S NAME (First)	Middle Last)								2. DATE	OF DEATH	-		3. TIME OF DEATH	
	WILLIE		DAY							November 14, 1995				1:55 A M	
	4. SOCIAL SECURITY NUMBER 242-09-001		5. SEX	6. AGE (In yrs. last	birtnday)	IF UNDER	DAYS	HOURS	MIN.	(Monti	of BIRTH h, Day, Year)	1907	Count	HPLACE (State or Foreign hy) eenfield, NC	
	9a. FACILITY NAME (If not in			9b. CITY	, TOWN	OR LOCAT	ION OF DE				JNTY OF D				
DIRECTOR	Southern	tal		C1	into	on, N	lary1	land		Pri	ince	Georges			
EC	10a. STATE	10b. COUNTY			10c. CIT	Y, TOWN C	OR LOCA	TION						10d. INSIDE CITY	
	Maryland		e George	s	C	lint			land	ł		1		YES 2 NO	
RAI	9106 Pine						10	r. ZIP COE						WHAT COUNTRY?	
FUNERAL	11. MARITAL STATUS	ATEM P		IT EVER IN U.S. ARI	MED	12	WE OF		735	MIC OBIOIN	t? (Specify)	_	_	States E - American Indian,	
BY FU	1 Never Married 2 3 Widowed 4 Divo			YES 2 N			If yes, sp	ecify Cub		in, Puerto	Rican, etc.)	ee (ii No—	Spec	ok, White, etc.	
		EDENT'S EDUC			CEDENT'S					16b	KIND OF E	USINESS/IN	DUSTRY		
COMPLETED	Elementary/Secondary (y highest grade 0-12)	College (1-4 or 5	- Wa	ve kind of v Do NOT us	vork done se retired.)	aunng mo	ost of work	ing						
MPL	12				Cosm	eto1	ogis	t				Priv	ate		
00	17. FATHER'S NAME (First, M							18. MO1	HER'S NA	ME (First,	Middle, Meid	on Surname)			
ш		s Greei	n						Clar	a Hi	cks				
TO B	19a. INFORMANT'S NAME (ber, City or 1				
	Lela Wor								Tem		Hills				
	20s. METHOD OF DISPOSIT 1 X Burlel 2 Cremetic 4 Donation 6 Other	on 3 🗆 Remo	ovel from State	20b. PLACEA cemetery, cree Har	netory or o	ther plece)			rk	20c. LOCATION — City or Town, Stells 11/18 Landover, MD					
	21. SIGNATURE OF PUNETIA	0							ESS OF FA		o Fran				
	Mei	8	Pope X	7.			Alexander S. Pope Funeral Homes 5538 Marlboro Pike Forestville, MD 2074								
	23. PART i. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate														
			DUE TO	(OR AS A CONSEC	DUENCE O	F):									
NO	Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF):														
CERTIFICATION	If any, leading to imme	(OH AS A CONSEC	SECURICE OF):												
N N	CAUSE (Disease or Injury that initiated events DUE TO (OR AS A CONSEQUENCE OF):									-					
Ē	resulting in death) LAST														
CEI			d												
	PART II. Other significa	death but not n	not resulting in the underlying cause given in					Part i, 24a. WAS AN AUTOPSY PERFORMED?			24	b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO			
EDICAL	Renal]	Failure	e; Anemia	a						1 TYES 2 XNO				OF DEATH?	
ME											_			1 YES ZX NO	
	DID TOBACCO U	JSE CONTI	RIBUTE TO CA						CERTAI	N□					
PHYSICIAN:	25. WAS CASE REFERRED T EXAMINER?	TO MEDICAL	HOSPITAL:	26. PLAC	E OF OEA	TH (Check									
YSI	1 TES 2 XNO			ER/Outpatient 3	tient 3 DOA 4 Nursing Home 5 Residence										
	27. MANNER OF OEATH 1 Natural 5	Pending	28a. OATE O	Day, Year)		JURY	W	JURY AT DRK?			SCRIBE HO	V INJURY O	CCUREO		
ВУ	2 Accident	Investigation	N,			/A ^M		YES 2	X NO		N/A			On the Manhard	
03	3 Suicide 6 4 Homicide	Could not be determined	building	OF INJURY — At ho , atc. (Specify)		attreet, tec	логу, отн	ce		28t. LOCATION (Street and Number or Rural Route Number, City or Town, State)				ribute Number,	
E	An ormitien W			-	A/K							N/A			
COMPLETED	(Uneck only	2.00	CIAN: To the beat of R: On the beets of											(a) and menner as stated.	
E	29b. SMINATURE AND TITLE OF CERTIFIER				Ann		-	29c. LI	CENSE NU	MBER		29d. D/	ATE SIGNE	D (Month, Day, Year)	
D 19545								Nov.	14, 1995						
5	30. NAME AND ADDRESS C	F PERSON WH	O COMPLETED CAL	JSE OF OEATH (ITE	М 27) (Туре	, Print)			1034				TIO V 1	474 1777	
	Philip Wis	stosky.	MD 618	38 Oxon I	Hill	Road	1 #8	07	0xon	Hil:	1. Ma	rv]an	d 20	745	
	31. DATE FILED (Month, Day,	Ybar)	32, MEGISTR	AR'S SIGNATURED	1.11										
	DEC	8 1995	Jana	O (C) CONTRACTOR (C)									_	DUMM-18 Day 1/80	

the give

	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the fune be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burlal, cremation, or removal.	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical exam
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	2	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the f be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	×

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	1 - STATE REGISTRAR	STATE OF M	IARYLAND	/ DEPAR	TMENT O	F HEALTH AND	D MENT	TAL HYGIEN			
	1. DECEOENT'S NAME (First, Middle, Last)						2. D/	ATE OF DEATH			3. TIME OF DEATH
	Gladys Price DR	RISCOLL						vember 2		995	2:00 A. M
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs.	last birthday)	IF UNDER 1 YE	AR IF UNDER 24 HR	s. 7. DA	TE OF BIRTH		0. BIRTH	IPLACE (State or Foreign
	109 01 4523	1 🗆 M 2 🖳 🖡	91	YRS.		Days Hours Min. (Month, De C.			Day Year) Country)		
L	Doctors Communi		- 1		% CITY, TO	WN OR LOCATION OF	DEATH			NTY OF D	George's
DIRECTOR	RESIDENCE OF DECEDENT	cy nospic	.al		Laiin	alli			11.	Ince	George 5
Ä	10a. STATE 10b. COUNTY		_	10c. CIT	Y, TOWN OR L	CATION					10d. INSIDE CITY LIMITS?
		ce George	's	Bo	wie						YES 2 NO
FUNERAL	10e. STREET AND NUMBER					101. ZIP CODE 20715					WHAT COUNTRY?
N N	2919 Blueberry L									rrea	States
	11. MARITAL STATUS 1 Never Married 2 Married	12. WAS DECEDENT FORCES? 1	YES 2X		If yes	DECENDENT OF HIS I, specify Cuben, Me	xican, Puer	GIN? (Specify Yes	or No-	14. RACI	E — American Indian, k, White, etc.
₽	XX Widowed 4 □ Divorced	IF YES, GIVE W	AR OR DATES		1 🗆	YES 2 NO Sp	ecify:			Speci	wy: White
8	15. DECEDENT'S EDUC (Specify only highest grade	CATION COmpleted	16a.	DECEDENT'S	USUAL OCCU	PATION		16b. KIND OF BUS	SINESS/INC	DUSTRY	WILLE
9	Elementary/Secondary (0-12)	College (1-4 or 5+)			g most of working					
COMPLET	12		Н	omema	ker			Own H			
8	17. FATHER'S NAME (First, Middle, Last) Alfred Law					The second secon	name (Fin	st, Middle, Maiden WIL	Surname)		
00	19s. INFORMANT'S NAME (Type/Print)					eet and Number or Ru					
٩	Dolores D. Sharp			2919	Blueb	erry Lane	Bow	ie Mary	land	207	15
	20a. METHOD OF DISPOSITION 1 □XBurlel 2 □ Cremation 3 □ Remo	oval from State	20b. PLAC	E AND DATE	OF DISPOSITION	N (Name of	D	ATE 20c. LO	CATION -		
	4 Donation 8 Other (Specify)	Sacred Heart Cemetery 11/29/95 Bowie Maryland									land
	21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEE		\supset		ert E. Ev		Funeral	Home	e, P	.A.
	Robert E.	Cua	no	Tres	160	00 Annapo	olis	Rd. Bow	ie Mo	d. 20	
	23. PART i. Enter the diseasea, or o shock, or heart failure.	complications that	couned the	deeth. Do i	not enter the	mode of dying, a	uch aa c	ardiac or reapi	ratory arr	reat,	Approximate
	shock, or heart failure. Liet only one ceuse on each line. IMMEDIATE CAUSE (Final disease or condition)										Internal Detween
					1	,					Interval Between Onset and Death
	iMMEDIATE CAUSE (Final disease or condition reaulting in death)				sho	ck					
	disease or condition				sho.	ck					Onset and Death
NOI	disease or condition resulting in death) Sequentially list conditions,	DUE TO		I C BEOUENCE O	Sho	ck ml,	nfas	rchon	7		Onset and Death
CATION	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING	a, Caro	dragen or as a cons te or as a cons	DEOUENCE O	F):	ck ml ,	nfæ	rch on	7		Onset and Death
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FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

Rache1

4. SOCIAL SECURITY NUMBER

577-56-1681

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Pages 1, 2, 3 should 9e. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH 3305 Gumwood Drive Hyattsville DIRECTOR RESIDENCE OF DECEDENT 10c. CITY, TOWN OR LOCATION 10b. COUNTY Maryland Prince George's Hyattsville permit. FUNERAL 10e. STREET AND NUMBER 20783 3305 Gumwood Drive the burial-transit hours after death. Page 6 may be retained by the hospital or attending physician. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No-If yes, specify Cuban, Mexicen, Puerto Rican, etc.)

1 YES 2 NO Specify: 1 Never Merried 2XX Merried IF YES, GIVE WAR OR DATES BY 3 Widowed 4 Divorced ETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION (Specify only highest Ď Elementery/Secondary (0-12) College (1-4 or 5+) COMPL 12 Registered Nurse page 5 should be detached notified at once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surneme) Landis Jesse Lucy 19a, INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Wendall J. Evans same as #10 be 20e METHOD OF DISPOSITION
1.4 Suriel 2 Cremation 3 Removal from State
4 Donetion 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of DATE must funeral director, Fort Lincoln Cemetery 12/9/1995 examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSET Donald V. Borgwardt Funeral Home, P.A. filled in by the medical 23. PART I. Enter the diseases, or complications that caused the death. Do not anter the mode of dying, such as cardiec or respiratory arrest, ahock, or heart fallure. List only one cause on each line 9 IMMEDIATE CAUSE (Final the wit.... 24 diseese or condition completely reaulting in death) traumatic event, crem DUE TO (OR AS A CONSEQUENCE OF burial, executed CERTIFICATION and Sequentielly list conditions, DUE TO (OR AS A CONSEQUENCE prior to If any, leading to immediate physician 28 ceuse. Enter UNDERLYING CAUSE (Disease or injury C certificate other DUE TO (OR AS A CONSEQUENCE OF) that initiated events attending resulting in death) LAST 0 death Mental Injury, the PART II. Other significent conditions contributing to deeth but not resulting in the underlying cause given in Part i. MEDICAL een signed by the shows any has been s Dept. of H YES | NO | UNCERTAIN | DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one The Item certificate h OTHER: 1 TYES 2 NO 1 | Inpatient 2 | ER/Outpatient 3 | DOA 4 Nursing Home 5 Residence 6 Other (Specify) PHYSICIAN: 10 TO THE HOSPITAL OR ATTENDING PHYSICIA TO THE FUNERAL DIRECTOR: After this certibe filed within 72 hours after death with the IMPORTANT: If Item 28 is marked, or 27. MANNER OF DEATH 28c. INJURY AT WORK? 28e. DATE OF INJURY 28b. TIME OF INJURY 1 Naturel 2 Accident 5 Pending Investigation м 1 YES BY 28e. PLACE OF INJURY — At home, farm, street, tectory, office building, etc. (Specify) 3 Sulcide 6 Could not be determined COMPLETED 4 Homicide 29e. CERTIFIER (Check only (Ch 2 MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and menner as stated. 29b. SIGNATURE AND TITLE OF CHATTERING 29c LICENSE NUMBER BE your ロス 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Stanley L. Lugerner, M.D. 4700 Berwyn House Rd., #105 College Park, Maryland 31. DATE FILED (Month, Day, Year) 32 REGISTRAR'S SIGNATURE

his d'aveler hardelle

DEC 07.1995

L.

6. AGE (In yrs. lest birthday)

90 YRS.

5 SEY

1 M 2 XX

CERTIFICATE OF DEATH

Evans

DAYS

IF UNDER 1 YEAR IF UNDER 24 HRS.

HOURS

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REG. NO. 2. DATE OF DEATH 3. TIME OF DEATH 1995 YEAR 8:00 A.M December 6, 7. DATE OF BIRTH OCt. 29, 1905 8. BIRTHPLACE (State or Foreign West Virginia 9c. COUNTY OF DEATH Prince George's 10d. INSIDE CITY
VLIMITS?
1 YES 2 NO 10g. CITIZEN OF WHAT COUNTRY? United States 14. RACE - American Indian, Black, White, etc. Specify: White 16b. KIND OF BUSINESS/INDUSTRY Sibley Hospital Wiland 20c. LOCATION - City or Town, State Brentwood, Maryland 4400 Powder Mill Rd. Beltsville, Md. 20705 Interval Between Onset and Death 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE 24e. WAS AN AUTOPSY PERFORMED? 1 TES 2 NO OF DEATH? 1 TES 2 NO 28d. DESCRIBE HOW INJURY OCCURED 281. LOCATION (Street and Number or Rural Route Number, Clin or Town, State)

FOR 1 . STATE

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAR		CERTIF	ICALE	IF DEAIL	1	REG. NO.			
	1. DECEDENT'S NAME (First, Middle, Last) LUCILLE COV	INGTON E	DWARDS			MO	TE OF DEATH DA	, 3. 19	YEAR	1:30 PM
	4. SOCIAL SECURITY NUMBER 223-52-3597	The second secon	rs. lest birthday) 85 vns.	IF UNDER 1 YE MONTHS DAY		HRS. 7. DA MIN. (Mi	TE OF BIRTH onth, Day, Ybar)		8. BIRTHPLA Country)	NCE (State or Foreign
- 8	9a. FACILITY NAME (If not institution, give st			AL OUT N TON	VN OR LOCATION		11 5 19		TY OF DEAT	
OR	Livingston Health			Fort Washington, MD				Prince Georges		
2	RESIDENCE OF DECEDENT 10a, STATE 10b, COUNTY		1						1.00	
DIRECTOR	Maryland Princ	e Georges		Fort Washington, Maryland					17	d. INSIDE CITY LIMITS? KYES 2 NO
FUNERAL	12021 Livingsto	n Road							ted St	
BY FUN	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN U. FORCES? 1 YES 2 IF YES, GIVE WAR OR DATE	2 X NO	If yes	DECENDENT OF It, specify Cuban, YES 2 NO	Mexican, Puer	GIN? (Specify Yes to Rican, atc.)	or No-	14. RACE — Black, W Specify:	American Indian, hita, etc. Black
	15. DECEDENT'S EDUC	CATION 16	a. DECEDENT'S	LISUAL OCCU	PATION	I	16b, KIND OF BUS	INESS/IND	IISTRY	
	(Specify only highest grade	completed)	(Give kind of v	work done durin	most of working		TOOL PORTE OF BOT	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	001111	
COMPLETED	Elementary/Secondary (0-12)	College (1-4 or 5+)		tic Wo	rker		Pı	civat	e	
ΞI	17. FATHER'S NAME (First, Middle, Last)				40 440074401	DIO NAME (E)	st, Middle, Maiden	0		
	Daniel Covingto	n				ry Phi		Sumame)		
BE			1							
2	19a. INFORMANT'S NAME (Type/Print)						umber, City or Tow			
	Mack D. Edwards		4240	Sultia	ind #102	Sult.	land, M	207	40	
}	20s. METHOD OF DISPOSITION 1 (28 urls) 2 (1 Cremation 3 (1 Remoted to 1 Donation 1 (1 Other (Specify)	oval from State cameta	ry, crematory or or Linc	ther place)			2/0		city or Town,	
	21. SIGNATIONE OF FUMERAL SERVICE LIC			22 NAM	E AND ADDRESS	OF FACILITY				TID .
	Alexander S. Pope Funeral Homes 5538 Marlboro Pike Forestville, MD 207								MD 20747	
	23. PART I. Enter the diseases, or control shock, or heart failure. IMMEDIATE CAUSE (Final disease or condition	complications that collect the List only one called on each Urosepsis	ne death. Do r h line.							Approximate Interval Between Onset and Death
	resulting in death)		1 week							
N	Sequentially list conditions, Alzheimer dementia DUE TO (OR AS A CONSEQUENCE OF):									4 years
CERTIFICATION	if any, leading to immediate cause. Enter UNDERLYING			r):						
3	CAUSE (Disease or Injury	c. Vaginal Ble	eding	D						8 months
E	that initiated events resulting in death) LAST	DOE TO (ON AS A CO	JN3EOVENUE VI	۲).						
E		d								<u> </u>
	PART II. Other significant condition	a contributing to death but	not resulting	in the under	lying cause giv	ven in Part i				ERE AUTOPSY FINDINGS
EDICAL							PERFO			MILABLE PRIOR TO OMPLETION OF CAUSE
							1 TYES 2	NO NO		F DEATH?
Σ	DID TOPACCO HEE COATE	DIDLITE TO CALLEE OF	DEATH V	C D NO	D UNICE	DTAIN!			1 1	YES 2 X NO
Z	DID TOBACCO USE CONTI					KIAIN L				
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	PLACE OF DEA	OTHER:	one)					
YS	1 YES 2 NO	1 - Inpetient 2 - ER/Outpetie			Home 5 Real					
H	27. MANNER OF DEATH	(Month, Day, Year)	28b. TIM	JURY 28	WORK?	28d.	DESCRIBE HOW	NJURY OCC	CURED	
BY	1 Netural 5 Pending 2 Accident Investigation	N/A	N/A	M 1	YES 2 X	NO	N/A			
	3 Suicide 6 Could not be	28a. PLACE OF INJURY — building, atc. (Specify)	At home, farm,	street, factory,	office	281. 1	OCATION (Street City or Town, State	and Number	or Rural Rout	te Number,
COMPLETED	4 Homicide determined	only or lown, orale,		/A						
9	29a. CERTIFIER , X CERTIFYING PHYSI	ICIAN: To the best of my knowled	ine deeth occur	and at the time	data and place a	and due to the	course(s) and ma		·	
₹	[Crieck Orly	R: On the basis of examination a								nd manner se stetad.
8				,, .,						
m l	296. MONATURE AND TITES OF CERTIFIE	~ 100	1+	-0.40	29c. LICEN	ISE NUMBER		29d. DAT	E BIGNED (M	ofter Day (May)
0 8	moun	JW KINUL	veno	cur	D-2	24535		-	101	4/40
2	30. NAME AND ADDRESS OF PERSON WH Dr. Laxmi Berwa	7700 Old Br			Suite 10)1 C1i	nton. M	207	35	,
	31. DATE FILED (Month, Day, Yber)				OLLE IU	,	LEOII, III		<i></i>	
	DEC - 8 199	32. REGISTRAR'S SIGNATI	x-Kandall							

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IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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3. TIME OF OEATH

8. BIRTHPLACE (State or Foreign West Virginia

8.40PM

YEAR

1995

REG. NO.

2. DATE OF GEATH

December 1,

FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

Evelyn Lucille

31. DATE FILED (1407) 07 4" 1995

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DIVISION OF VITAL RECORDS, P.O. BOX 68760	i
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	236-20-287]	L	1 M 2 F	73	YRS.	MONTHS	DAYS	HOURS	MIN.	Nov.	29,	1922		t Virginia
	Sa. FACILITY NAME (If not	institution, give	street and number)			9b. CITY	TOWN C	R LOCATI	ON OF O	EATH		9c. COU	NTY OF OE	ATH
DIRECTOR	A STATE OF THE PARTY OF THE PAR		cal Hospi	tal				Fal	lstc	n			H	larford
5	RESIDENCE OF DE	10b. COUNT	TY		10c. Cl	TY, TOWN C	OR LOCAT	ION				10d. INSIDE CITY		
	Maryland	and Harford				Abingdon					don	LIMITS?		
LONERAL	10e. STREET AND NUMBER						101	ZIP COD				10g. CIT	IZEN OF WI	HAT COUNTRY?
	502 Ramblewood Drive								21	.009				USA
		11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 X Divorced 12. WAS OCCEOENT EVER IN U FORCES? 1 YES IF YES, GIVE WAR OR DAT			2 NO If yes, specify Cubsn, Mexican, Puerto					ın, Puerto		Yes or No	14. RACE Black, Specify	White with White
7		ECEDENT'S EDI		186	. OECEOENT'S				na	160	. KIND OF	SUSINESS/INI	DUSTRY	21111
	Elementary/Secondary		College (1-4 or 5	+)	life. Do NOT u	use retired.)				3 13		77		
COMP EE						HOI	nema					Hom	e	
3	17. FATHER'S NAME (First,		nn) Somer								Middle, Mald			
מ		England - County						1 Dee						
2	190. INFORMANT'S NAME									fown, State, Zi		0.7.00.4		
	Lena M. Su		IISKI				-		Коа			ore,		
	20e. METHOD OF CISPOS 1 Duriel 2 X Cremat	tion 3 🗆 Rei	moval from State	cemeter	CE AND OATE	of DISPOS other place)	SITION (No	me of		DAT	E 20c.	LOCATION —	City or Tow	in, State
	4 Donation 5 Oth			-hR	. A. F	erris	5 &	Co.,	Inc	. 12	<u>/5/95</u>	West	Ches	ter, PA
1 Burlet 2 K Cremation 3 Removal from State Surface Air Deposition (Name of Language of Conference)												bingd	on, M	ome, P.A. d. 21009
	IMMEDIATE CAUSE (F disease or condition resulting in death)	Final	a. Acut	e Core	onary	Art					diac or re	spiretory ar		Interval Between
	IMMEDIATE CAUSE (F	ditiona, nediata LYING nijury	a. Acut DUE TO ASCV DUE TO	e Core	Onary NSEQUENCE	Art					diac or re	spiretory ar		Interval Betwe
	IMMEDIATE CAUSE (F disease or condition resulting in death) Sequentially list cond if any, leading to imm cause. Enter UNDERL CAUSE (Disease or in that initiated events	ditiona, nediata LYING anjury	a. Acut DUE TO DUE TO C. DUE TO d.	e Coro	Ine. Onary NSEOUENCE	Art	ery	Di	seas	5 e	24a. WAS	AN AUTOPSY	24b.	Interval Betwee Onset and Date of the Constant Date
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TED BY PHYSICIAN: MEDICAL CERTIFICATION	IMMEDIATE CAUSE (f disease or condition resulting in death) Sequentially list cond if any, leading to imm cause. Enter UNDERL CAUSE (Disease or in that initiated events resulting in death) LA PART II. Other algniff DID TOBACCO 25. WAS CASE REFERRED EXAMINER? 1 XYES 2 NO 27. MANNER OF OEATN 1 X Netural 5 [2 Accident]	ditiona, nediata LyiNG hjury AST Cant conditional Cond	a. Acut DUE TO DUE TO C. DUE TO d. DUE TO TRIBUTE TO C. HOSPITAL: 1 Inpetient 2 28e. OATEC (Agriculture) 1 28e. PLACE	COTO O (OR AS A CO O (OR AS A CO O (OR AS A CO O (OR AS A CO O (OR AS A CO O (OR AS A CO	On a ry NSEOUENCE (NSEOUENCE (NSEOUENCE (NSEOUENCE (NSEOUENCE (NSEOUENCE (NSEOUENCE (NSEOUENCE (NSEOUENCE (Art OF): OF): OF): In the un ATH (Check OTHE OTH OTH	ery nderlyin NO [only one) Pi: raing Hon 28c. IN. 1 [Di:	given in	Part I.	24a, WAS PERI 1 YES er (Specify) SSCRIBE NO	AN AUTOPSY FORMED? 2 NO W INJURY OC.	24b.	WERE AUTOPSY FINDIN ANAILABLE PRIOR TO COMPLETION OF CAUSI OF DEATH?
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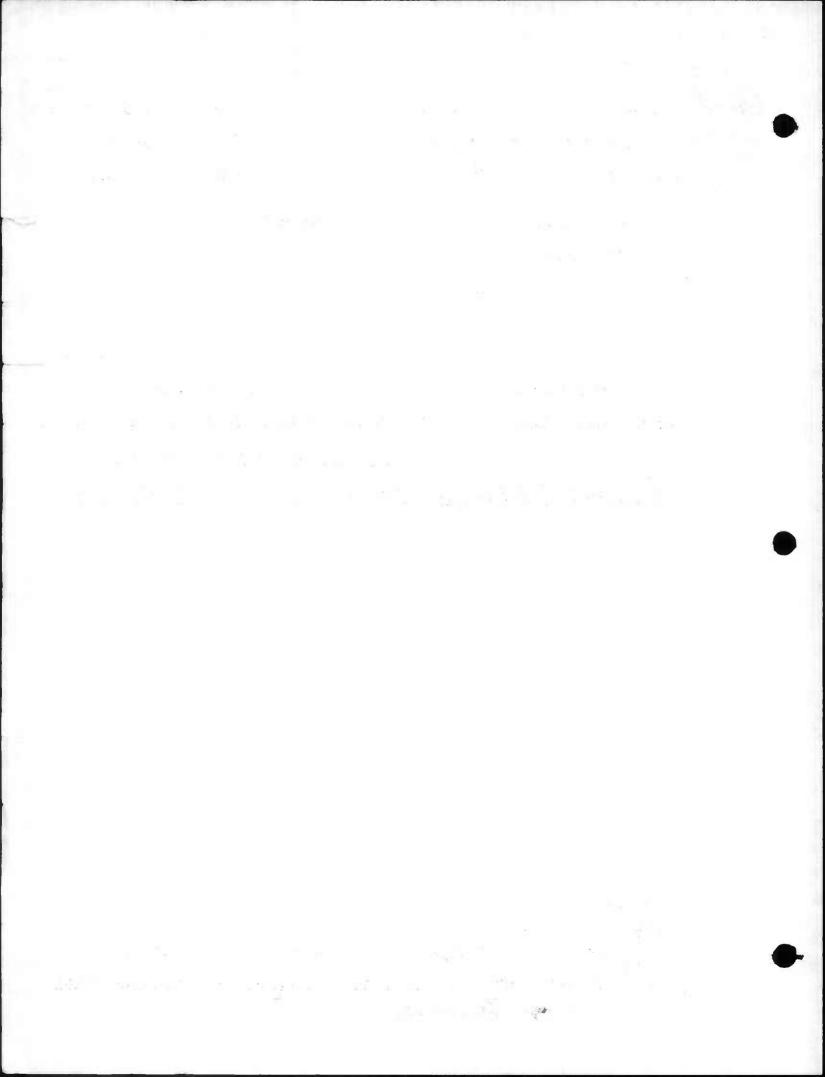
Jam Saucer Randall

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

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DHMH 16 Rev 6/95



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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 74 hours after death. Page 6 may be retained by the hosp TO THE FUNERAL DIRECTOR. After this certificate has been signed by the afteroding physician and completely filled in by the funeral director, page 5 should be detached be felled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to buriel, cremation, or removal. IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or Other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 - STATE REGISTRAR **CERTIFICATE OF DEATH** REG. NO t. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH YEAR 3:578 27, Mary Louise Frey Nov. 1995 7. DATE OF BIRTH (Month, Day, Year) 4. SOCIAL SECURITY NUMBER IF UNDER 1 YEAR 8. BIRTHPLACE (State or Foreign IF UNDER 24 HRS. DAYS Ohio 262 36 6426 65 March 24,1930 9e. FACILITY NAME (If not institution, give street and nu 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Anne Arundel Medical Center Annapolis Anne Arundel 10b. COUNTY 10c. CITY, TOWN OR LOCATION toe. STATE tod. INSIDE CITY 1 TES 2 THO Maryland Anne Arundel Crofton FUNERAL 10e. STREET AND NUMBER 10f ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 1710 Farmington Court 21114 United States 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. RACE — American Indian, Black, White, etc. 1 Never Merried 2 Merried 1 TES 2 NO Specify: Specify: BY 3 Widowed 4 Divorced White No 16e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use relied.)

Designer COMPLETED 15. DECEDENT'S EDUCATION 165 KIND OF BUSINESS/INDUSTRY Elementery/Secondary (0-12) College (1-4 or 5+) Graphic Illustrations Graphic Illustrations 17. FATHER'S NAME (First, Middle, Lest) 18. MOTHER'S NAME (First, Middle, Maiden Surneme) Andrew Hilton Myrtle Wetzler 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Andrea M. Frey 772 Farmington Court Crofton Maryland 20e, METHOD OF DISPOSITION
1 ☒ Burlel 2 ☐ Cremation 3 ☐ Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION — City or Town, State 4 Donetton 5 Other (Specify) Lakemont Memorial Gardens 12/1/95 Davidsonville Md. 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Robert Robert E. Evans Funeral Home, P.A. Uls 16000 Annapolis Rd. Bowie Md. 20715 23. PART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, abock, or heart failure. List only one cause on each line. Approximata Interval Between Onset and Daath IMMEDIATE CAUSE (Final Obstructive Lung Disease disease or condition Chronic loyeors reaulting in death) DUE TO (OR AS A CONSEQUENCE OF MEDICAL CERTIFICATION Sequantially list conditiona, DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events DUE TO (OR AS A CONSEQUENCE OF): reaulting in death) LAST PART II. Other algorificant conditions contributing to death but not reaulting in the underlying cause given in Part I. 24e. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS PERFORMED? AVAILABLE PRIOR TO COMPLETION OF CAUSE 1 - YES 2 NO 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Ch k only one HOSPITAL:
1 Nopetient 2 ER/Outpatient 3 DOA 1 YES 2 NO 4 Nursing Home 5 Residence 8 Other (Specify) 28c. INJURY AT WORK?
1 YES 2 NO 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28d. DESCRIBE HOW INJURY OCCURED 1 Natural 2 Accident 5 Pending BY 3 Suicide 28e. PLACE OF INJURY — At home, term, street, tectory, office building, atc. (Specify) 281, LOCATION (Street end Number or Rural Route Number, City or Town, State) 6 Could not be determined COMPLETED 4 Homicide 29e. CERTIFIER (Check only 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) end manner se stated. 2 MEDICAL EXAMINER: On the beste of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(e) and manner se stated. 29b. SIGNATURE AND TITZE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) Kuled 11-27-95 024809 Veller 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

Robert Peterson 600 31. DATE FILED (Month, Day, Year)

Address States 18 18 18 18 18 18

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

		REGISTRAN				CE	RHE	CAL	E OI	PUEA	1Н		REG. NO				
		1. DECEDENT'S NAME (First, A				17						MONTH	OF DEATH	AY 1.0	YEAR	3. TIME OF DEA	
,		4. SOCIAL SECURITY NUMBE	M	5. SEX	A AGE (In yrs. lest t	ring		R 1 YEAR	T as in more			mber 4	+, 19		9:00	
		213-74-8145		1 M 2 V F		90	YRS.	MONTHS	DAYS	_	MIN.	(Month	Day, Year)		Country		Foreign
plnods		8e. FACILITY NAME (If not inst	flution aive s			70		Oh CIT	/ TOWN	OR LOCATI	ON OF DE		. 6,		Net NTY OF DE	w York	
8 8	<u>~</u>	10410 Procte								r Spi		EAIM					
1, 2,	DIRECTOR	RESIDENCE OF DECE						0.1	TIVE	r Spi	Ting	_		MO	ntgo	nery	
	H H		10b. COUNTY				10c. CITY	r, TOWN	OR LOC	ATION						10d. INSIDE CIT	Υ
permit. Pages		Maryland	Mon	tgomery			Si	lvei	: Sp	ring						1 K YES 2	NO NO
E Ded	₹	10e. BTREET AND NUMBER							1	01. ZIP COD	E			10g. CITI	ZEN OF WI	HAT COUNTRY?	
physician. burial-transit	FUNERAL	10410 Procte	r Str	eet						20901	L			U	SA		
ysicii ırial-t		11. MARITAL STATUS 1 Never Married 2 X M	larried	12. WAS DECEDENT FORCES? 1						ECENDENT ((Specify Yes	or No-	14. RACE Black,	- American Ind White, etc.	len,
pe pe	B	3 Widowed 4 Divorc		IF YES, GIVE W	AR OR DA	ATES				8 2 X NO			, , , , ,		Specify	<i>/</i> :	
attending physician. se as the burial-trar		15. DECEI	DENT'S EDUC	CATION		16a. DECE	PITHAL	USUAL C	CCLIDAT	TION.		105	KIND OF BU	201500 (1115	A LOTTON	White	
8 2		(Specify only / Elementary/Secondary (0-1	nighest grade	completed) College (1-4 or 5 +	,—	(G/ve	kind of w		during n	nost of workli	ng	100.	KIND OF BU	SINE 33/IND	USINY		
spital ned fo	립	12	-,	College (1-4 or 5 +	'	Н	omem	aker	-			0	wn Hor	ne			
the hospital detached to once.	COMPLETED	17. FATHER'S NAME (First, Mide	dle, Lest)							18. MOT	HER'S NA		liddle, Melden				
B 6 8	BE C	Patrick McCu	e							E1	len	Donn	elly				
retained by the hospiti 5 should be detached notified at once.	10 B	190. INFORMANT'S NAME (Typ				19b.	MAJLINO	ADDRES	S (Street				er, City or Tow	n, Stete, Zip	Code)		
	🏲	Sr. Mary Ann	Farr	ington		104	410	Proc	ter	Stre	et,	Silv	er Spi	ing,	MD	20901	
~ 2 4		20e. METHOD OF DISPOSITIO 1 ☑ Burlel 2 ☐ Cremetion		oval Imm State	20b.	PLACEAN	DDATEO	E DISPO	NOTION /	Name of		0.175	200 10	CATION	City on Town	m, State	
Page 6 mail director, p		4 Donation 6 Dother (S	Specify)		- Ga	ite o	f He	avei	n Ce	emete:	ry 1:	2/9/9	5 Si	lver	Spri	ng, MD	
death. Pag tuneral di i. examiner		21. SIONATURE OF FUNERAL	SERVICE LIC	ENSEE	7.	0		22.	NAME /	ANO ADDRE	SS OF FA	CILITY				Inc.	
		· Man	4	7	L.	.//										D 2090	1
hours after d d in by the or removal.		23. PART i. Enter the disc	eases, or c	omplications that	caused	the deat	h. Do n	ot enter	the m	ode of dy	ing, suci	h as card	ac or respi	ratory arr	est,	Approxim	
DOE		ahock, or hea iMMEDIATE CAUSE (Fina	irt tallure.	List only one ceu	se on ea	ach line.										Interval E	Between
in 24 attion,		disease or condition		Conges	stiv	e Hea	art	Fail	ure							Wks.	o Death
ompletely ompletely il, crema	- 1	resulting in death)	,			CONSEQU										WRO	to
executed and con to burial, matic er	z			Arter	iosc	lerot	ic 1	Hear	t D	iseas	e					Mos.	Yrs
h certificate be execute anding physician and co Hygiene prior to buria or other traumatic	CERTIFICATION	Sequentially list conditions, If any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF):															
cate lhysic e price	2	CAUSE (Disease or injury															
ding phygien		that initiated events DUE TO (OR AS A CONSEQUENCE OF): resulting in death) LAST															
atten atten 7, 0	병			1													
ires that the death certificate be executed within 24 is signed by the attending physician and completely fille Health and Mental Hygiene prior to burial, cremation, ws any Injury, or other traumatic event, the		PART ii. Other algnificent	condition	contributing to	death be	ut not rea	ulting l	n the u	nderiyi	ng cause	given in	Part i.	24a. WAS AN PERFOR			WERE AUTOPSY F	
5 25 5	EDICAL											_	1 TES 2			AVAILABLE PRIOR COMPLETION OF DF DEATH?	
	ME															1 YES 2	NO
law red as been lept. of 23 sh		DID TOBACCO US	E CONT	RIBUTE TO CA	USE O	F DEATI	H YE	s 🗆	NO E	UNC	ERTAIN	1 D					
N: The law requirements been State Dept. of Item 23 sho	PHYSICIAN:	25. WAS CASE REFERRED TO EXAMINER?	MEDICAL	HOSPITAL:		26. PLACE	OF DEAT)							
or It	YSI	1 YES 2 X NO		1 Inpatient 2	ER/Outp	atient 3	DOA	4 Nur		me 5 ₹5 Re	enidence	8 🗆 Other	(Specify)				
	F	27. MANNER OF DEATH 1 X Natural 5 Pe	adlas	28e. DATE OF (Month, Da			28b. TIME INJU		28c. IN	JURY AT		28d. DE\$6	CRIBE HOW II	NJURY OCC	URED		
OING PHYS After this death with s marked	BY		restigation					М		YES 2	NO						
TTENDI TOR: A after of	8		ould not be termined	28e. PLACE Of building,	etc. (Speci	— At home	e, term, si	treet, fac	tory, offi	Ice			TION (Street e r Town, State)	and Number	or Rural Ro	ute Number,	
OR ATTENDING DIRECTOR: After hours after death item 28 is ma	Ц	an ocations								_							
보 되었는	MPL			CIAN: To the best of													
TO THE HOSPITAL TO THE FUNERAL De filed within 72 I	COMPLET	2 MEDICA	AL EXAMINE	R: On the beels of ex	amination	and/or Inv	watigation	n, In my o	opinion,	death occur	red at the	time, data	and place, an	d due to the	o Cause(a)	and manner as a	stated.
HE H	BE	29b. SIGNATURE AND DITLE O	FCERTIFIER		11		v/	h		100	ENSE NUN	BER		29d. DATE	SIGNED (Month, Day, Year)	
2 2 3 W	0	away	170			aux				D02	404			1 :	2/5/9	5	
		Albert H.							* 0.5	+ 02	1,,,,,	C		m 2	0010	4001	
		31. DATE FILED (Month, Day, Yes			11	OU ST	TID	g or	тее	ι, 51	ıver	spr:	ing, M	ш 21	091U-	.4001	
		DEC 08 19	0E :	32. REGISTRAF	S SIGN	AL II											
		UEC 00 19	JJ /	was ware	~ 1 V	- Codes											

FOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

REGISTRAR		CERTI	FICATE OF	DEATH	R	EG. NO.						
1. DECEDENT'S NAME (First, Middle, Lest,		2. DATE OF I	DEATH		YEAR 3	. TIME OF DEATH						
MARG	GARET JEAN	FOSTER			NOVEM				5.48 P			
4. SOCIAL SECURITY NUMBER 577-38-9312	5. SEX 6	AGE (In yrs. lest birthday 84 YRS.	MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF 1 (Month, De OCt.	DIGTL		8. BIRTHPL Country)	ACE (Stere or Foreign Canada			
9. FACILITY NAME (If not Institution, give NATIONAL NAVAL)		TER	96. CITY, TOWN	OR LOCATION OF D	EATH			ONTGOMERY				
RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION									Dd. INSIDE CITY LIMITS?			
Maryland Mon	tgomery		Bethesda	ef. ZIP CODE			10a CITI	ZEN OF WH	YES 2 NO			
9001 Kirkdale Ro	ad			20817			log. or i	USA				
11. MARITAL STATUS 1 Never Married 2 Merried 3 Wildowed 4 Divorced	12. WAS DECEDENT EV FORCES? 1 IF YES, GIVE WAR	YES 2 X NO	If yes,	ECENDENT OF HISPA specify Cuben, Mexic ES 2 NO Specif	en, Puerto Rice		or No—	Black, \ Specify:	- American Indian, White, atc.			
15. DECEDENT'S ED (Specify only highest grad Elementary/Secondary (0-12)		(Give kind o	'S USUAL OCCUPAT of work done during r use retired.)		16b, Kil	OF BUS	INESS/INC	DUSTRY				
	2	Home	maker			vn Ho						
17. FATHER'S NAME (First, Middle, Last) Robert Wismer				Marie	Bailey		Sumame)					
19a. INFORMANT'S NAME (Type/Print)		19b. MAILI	NO ADDRESS (Stree	t end Number or Rural	Route Number,	City or Town	, State, Zip	Code)				
Muriel Foster				treet, Ba								
20e, METHOD OF DISPOSITION 1 % Suriel 2 Cremetion 3 Re 4 Donation 5 Other (Specify)	moval from State	20b. PLACE AND DAT cemetery, cremetory of Arlington	reordisposition/ rotherplace) Nationa	Name of 12/6/ al Cemete	95 DATE							
Cameton S Cremetion S Removal from State Cameton Cam												
22. PART I. Enter the dinagrae, or shock, or heart failure	complications that co that only one cause	on each line.							Approximate Interval Betwee Onset and Date			
disease or condition resulting in death)		3 hrs										
Sequentially flat conditions, If any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF):												
CAUSE (Disease or Injury that Initiated events resulting in death) LAST	CAUSE (Disease or Injury that Initiated events C. DUE TO (OR AS A CONSEQUENCE OF):											
PART II. Other algnificant conditi	ons contributing to de	sth but not resultin	g in the underly	ing csuse given in		e. WAS AN PERFOR	MED?		VERE AUTOPSY FINDING MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?			
							27		YES 2 NO			
DID TOBACCO USE CON	TRIBUTE TO CAUS				N L							
25. WAS CASE REPERRED TO MEDICAL EXAMINER? 1 YES 2 X NO												
27. MANNER OF DEATH 1 🔀 Netural 5 🗌 Pending	26s. OATE OF IN. (Month, Day,	JURY 28b. 1	TIME OF 28c. I	NJURY AT WORK?	28d. DESCR		NJURY OC	CURED	MACHIN			
2 Accident Investigation 3 Suicide 6 Could not 8 4 Homicide determined	26e. PLACE OF II	28e. PLACE OF INJURY — At home, farm, atraet, factory, offlic building, atc. (Specify)						Street and Number or Rural Route Number, State)				
CONSCR OTHY	rSICIAN: To the best of my								end manner as stated.			
295 SECHATURIS AND TITLE OF CERTIF	2 MEDICAL EXAMINER: On the basic of examination end/or investigation, in my opinion								Month, Day, Year)			
Manier	(VW1)			RES-0					30'95			
T.H.BURGESS, LT, MC, USN NATIONAL NA BETHESDA MD									TER			
31. DATE FILED (Month, Day, Year)	32. REDISTRAR'S	SIGNATURE						1=				
DEC 06 1995) Halla Dave	Geor Randall										

TO THE HOSPITAL, OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunal-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. DIVISION OF VITAL RECORDS, P.O. BOX 68760

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

06

BALTIMORE, MARYLAND 21215-0020

TO BE COMPLETED BY FUNERAL DIRECTOR

FOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

1 - STATE REGISTRAR	CERTIFICAT	TE OF DEATH	REG. NO					
1. DECEDENT'S NAME (First, Middle, Last)			2. DATE OF DEATH	ATH DAY YEAR 3. TIME OF DEATN				
EUGENE 1	FINCH		DEC 3,		2:00 P. M			
4. SOCIAL SECURITY NUMBER 5. SEX 8. AGE	. ,	DER 1 YEAR IF UNDER 24 HRS.	7. DATE OF BIRTN (Month, Day, Ybar)	8. BIRT	THPLACE (State or Foreign			
578-78-5979 ¹\(\overline{X}\) M 2 □ F 40			April 25,1	955 Was	shington,DC			
9s. FACILITY NAME (If not institution, give street and number) SOUTHERN MARYLAND HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH CLINTON PRINCE GEORGES						
RESIDENCE OF DECEDENT 10s. STATE 10b. COUNTY	IBC CITY TOW	N OR LOCATION			10d. INSIDE CITY			
MARYLAND PRINCE GEORGES	CLINT				LIMITS? YES 2 NO			
10e. STREET AND NUMBER		10f. ZIP CODE		10g. CITIZEN OF	WHAT COUNTRY?			
9211 Stuart Lane	W. 11.0 ADMITS	20735 3. WAS DECENDENT OF HISPA	NO OBIONE COLUMN	United	States CE - American Indian.			
XX Never Merried 2 Merried 12. Wis December 12. Wis December 12. Wis December 12. Wis December 12. Wis December 12. Wis December 13. Wis December 14. Wis December 14. Wis December 14. Wis December 14. Wis December 15.	S 2 NO	if yes, specify Cubsn, Maxic 1 YES 2 NO Speci	en, Puerto Ricen, etc.)	Bla	ick, White, etc.			
15, DECEDENT'S EDUCATION	16a. DECEDENT'S USUAL		16b, KIND OF BU	SINESS/INDUSTRY				
(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5 +)	(Give kind of work dor life. Do NOT use retired	ne during most of working d.)						
11	Custodian			rnment				
17. FATNER'S NAME (First, Middle, Last)			AME (First, Middle, Melden					
Otis Finch 198, INFORMANT'S NAME (Type/Print)	405 4444 1940 40000	Cather ESS (Street and Number or Rural	ine Howard					
		St., N.W., Wa			137			
Catherine Finch 20a. METHOD OF DISPOSITION 2	0b. PLACE AND DATE OF DISP			CATION — City or				
1 YBurisi 2 Cremstion 3 Removal from State	emetery, cremetory or other place Harmony Memo	cel	12/9 LAN	DOVER, 1	MD			
21, SIGNATURE OF PUNEITAL SERVICE LICENSEE		22. NAME AND ADDRESS OF F	ACILITY					
Mey & Hore &	MSSO	ALEXANDER S. 5538 Marlbord						
23. PART I. Enter the diseases, or completions that caus	ed the death. Do not en				Approximate			
ahock, or heart fallura. List only one cause on IMMEDIATE CAUSE (Final	each line.				Interval Batween Onset and Daath			
disease or condition resulting in death)	psis				246			
Detecto (ON A	CONSEQUENCE OF	C7 1 1			746			
Sequentially list conditions, DUE TO COMM	ACONSEQUENCE OF	mu		-	2//			
if any, leading to immediate cause. Enter UNDERLYING	ussothe	2 me	~					
CAUSE (Disease or injury that initiated events	CONSEQUENCE OF):	1111			6 0000			
resulting in death) LAST	Dlage 1	7.1,11			6 1005			
PART II. Other algorificant conditions contributing to death	but not resulting in the	underlying cause given in	Pert I. 24s. WAS A!		46. WERE AUTOPSY FINDINGS			
			PERFO		AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?			
					1 YES 2 NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE	OF DEATH YES	NO UNCERTA	IN 🗆					
25. WAS CASE REFERENCE TO MEDICAL EXAMINER?	26. PLACE OF DEATH (Che	eck only one)						
1 YES 2 1 1 1 Impatient 2 ER/O	utpetient 3 DOA 4 D	Nursing Nome 5 Residence						
28s. DATE OF INJUR (Month, Day, Year N/A	286. TIME OF INJURY	28c. INJURY AT WORK?	N/A	INJURY OCCURED				
28s. PLACE OF INJU	IRY At homs, ferm, street,		281, LOCATION (Street		el Route Number,			
8 Could not be building, stc. (S N/A	pecify)		N/A	"				
29s. CERTIFIER (Check only (Check only In Certifying Physician: To the best of my kn	owledge, death occurred at the	he time, date and place, and du	e to the cause(s) and me	onner ss stated.				
one) 2 MEDICAL EXAMINER: On the besis of sxamins	tion and/or investigation, in r	ny opinion, death occured at th	e time, date end place, e	nd due to the ceue	e(s) and manner as stated.			
296. SIGNATURE AND DITCH CERTIFIER	nD.	29c LICENSE NI	UMBER 7	29d. DATE SION	ED (Month, Pey, Year)			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF	DEATH (ITEM 27) (Type, Print)	18-6	1222	12	11173			
Dr. Laxmi Berwa 7700 Old Branch Avenue, Clinton, Maryland 20735								
31. DATE FILED (Month, Day, Year) 32, AEGISTRAR'S 3	GNATURO							
DEC 8 1995								

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within a hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

A Complete and the second seco

TO THE HOSPIAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 34 hours after death. Page 6 may be retained by the hospital or attending physician.

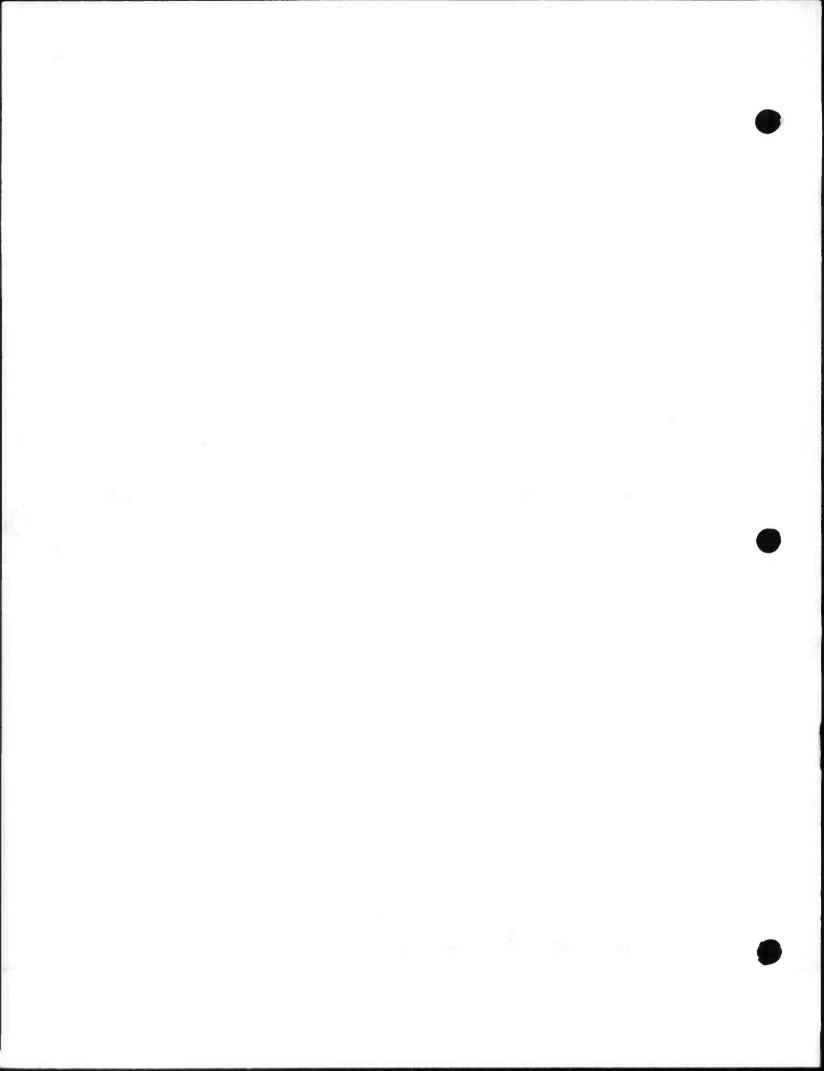
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiens prior to burial, cremation, or removal.

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Г	4. 3	OCIAL	SECUE

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAR CERTIFICATE OF DEATH REG. NO.										
	4 REPERCITO MANE (First Middle 1 - 0)										
DIRECTOR	HARRIET McDONAL FERGUSON 2. DATE OF DEATH MONTH DEC. 2 DAY 1995 8:30 PM M										
	4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In vis. last birthday) # UNDER 1 YEAR # UNDER 2 A MSC 7 DATE OF BUSTLIN										
	220-34-7507 1 M 2 XF 56 YRS. MONTHS DAY'S HOURS MIN. JAN. 7, 1939 MARYLAND										
	9e. FACILITY NAME (If not institution, give street end number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH										
	122 PROSPECT AVENUE EASTON TALBOT										
5	RESIDENCE OF DECEDENT										
뿐	10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS?										
	MARYLAND TALBOT EASTON 1 X YES 2 NO										
₹	100. STREET AND NUMBER 101. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY?										
	122 PROSPECT AVENUE 21601 USA										
FUNERAL	11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 1 Never Married 2 Married 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yea or No— 14. RACE — American Indian, 16. White, etc.										
BY	IF YES, GIVE WAR OR DATES 1 YES 2 XNO Specify: Specify:										
	WHITE										
TED	15. DECEDENT'S EDUCATION (Specify only highest grade completed) 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF SUSINESS/INDUSTRY										
ا ڐ	Conege (1-4 of 5+)										
COMPLET	12 SECRETARY HOSPITAL										
	17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Surneme)										
H	WILLIAM McDONAL EDNA COOPER										
2	19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street end Number or Rural Route Number, City or Town, State, Zip Code)										
	KAREN L. WHITBY 12 N. HANSON ST., EASTON, MD 21601										
	1 CyBurlel 2 Cremation 3 Removal from State										
	4 Donation 6 Other (Specify) MD. VETERANS CEMETERY 12-6 BEULAH, MD 21. SIGNATURE OF FUNERAL SERVICE LICENSEE										
	NEWNAM FUNERAL HOME, P.A.										
	MOHN Z. MERCERON CESP 200 S. HARRISON ST. FASTON, MD										
	23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,										
	IMMEDIATE CAUSE (Finel										
	disease or condition resulting in death)										
	DUE TO YOU AN A CONFEQUENCE OF										
Z	Sequentially list conditions, July 10 the as a consequence of Juny Kidunoca 3 may										
Ĕ	If any, leading to immediate										
CERTIFICATION	cause. Enter UNDERLYING CAUSE (Disease or Injury										
	that initiated events DUE TO (OR AS A CONSEQUENCE OF):										
当											
	PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY. 24s. WERE AUTOPSY FINDINGS										
EDICAL	PERFORMED? AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?										
밀											
₹	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN										
PHYSICIAN:	MAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Duck only one)										
S	EXAMINER? 1 VES 2 NO 1 Inpetient 2 ER/Outpetient 2 DOA 4 Norsing Home 5 Residence 8 Dither (Specify)										
Ë	TO MANNIER OF DENTH 286. DATE OF BAUURY 280. TIME OF 280. INJURY AT 286. DESCRIBE HOW INJURY OCCURRED										
	1 Natural 5 Pending (Month, Day, Year) INJURY WORKY W + Ves 2 No										
ă I	2 Society 20s. PLACE OF INJURY — At home, farm, street, factory, office 28t. LOCATION (Deed not A separate in red its and its angle in the injury of its angle in the injury of its angle in the injury of its angle in the injury of its angle in the injury of its angle injury of its										
<u> </u>	4 Hamicide determined building, etc. (Specify)										
COMPLETED	29e. CERTIFIEN CERTIFYING PHYSICIAN: To the heat of my begulades death any and the last of my begulades death and the las										
불Ⅱ	CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) and manner se stated. One) MEDICAL EXAMINER: On the best of examination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(e) end menner se stated.										
8	an aparterine she was a considered \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \										
H H	29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year)										
ဥ 🖡	6. NAME AND AUTORESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Typo, Print)										
	Control of the contro										
	R. LANE WROTH, M.D., P.O. BOX 290, ST. MICHAELS, MD 21663 1. DATE FILED (Month, Day, Vebr) 32_REGISTRAR'S SIGNATURE										
	14 4 0 4										
	DFC 05 1995 Gala d'audien Karlell										



DIVISION OF VITAL RECORDS, P.O. BOX 68760

anded 110,	11/30/33,	ri.w.c., noward co.	
FOR 1 STATE		STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYG	IENE

	1. DECEDENT'S NAME (First, Middle, Last)					-	DEA	-	2. DATE OF DEATH	IV .	YEAR	3. TIME OF DEATN	
	JOHN A FLAYFIEL							NOV 23 1995 710 pm					
BY FUNERAL DIRECTOR	4. SOCIAL SECURITY NUMBER 5. SEX 6. / 6. / 6. / 6. / 6. / 6. / 6. / 6.		6. AGE (In yrs.)	M		DAYS	YS HOURS MIN. (Month,		2. DATE OF BIRTH (Month, Day, Year) Aug 1, 19	, Day, Year)		BIRTHPLACE (State or Foreign Country) Maine	
	9a. FACILITY NAME (If not institution, give a	treet and number)		TTT	9b. CITY, TOWN OR LOCATION OF DE					9c. COUNTY OF DEATH			
	Howard County General Hospital				Columbia					Howard			
					TY, TOWN OR LOCATION					10d. INSIDE CITY LIMITS?			
	Maryland Howard E					Ellicott City					1 YES ZV NO		
	3109 Wheaton Way						21043				United States		
	11. MARITAL STATUS 1 Never Married 2 X Married 3 Widowed 4 Divorced 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 X YES 2 NO IF YES, GIVE WAR OR DATES WWT I					13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yea If yea, specify Cuban, Maxican, Puarto Rican, atc.) 1 YES 2 NO Specify:					s or No- 14. RACE - American Indian, Black, White, atc. Specify: White		
	15. DECEDENT'S EDU			DECEDENT'S					16b, KIND OF BU	USINESS/INDUSTRY			
ETED	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4 or 5+)	(Give kind of work done during most of working life. Do NOT use retired.)									
COMPL	3			Salesman					Insurance				
00	17. FATNER'S NAME (First, Middle, Last) Alexander Flayfic	مآ			18. MOTHER'S NAME (First, Middle, Maiden Sur Katherine					_	memo) Beck		
BE	19a, INFORMANT'S NAME (Type/Print)	<u>e.r</u>		19b, MAILING	ADDRESS	(Street			Route Number, City or Tow			,con	
10	Jean Cline								Ellicott			21043	
	20a. METNOD OF DISPOSITION 1 X Buriel 2 Cremetion 3 Rem 4 Donation 8 Dither (Specify)	ovel from State	cemetery	crematory or o	ther placel			ane			- City or To	1	
	21. SIGNATURE OF FUNERAL SERVICE LI	CENSEE	I Gall	LSOII .	22. F	Forest Veterens 11-28 Owings Mills, MD 22. NAME AND ADDRESS OF FACILITY Harry H. Witzke Funeral Home, Inc.							
												City 21043	
NEDICAL CERTIFICATION	IMMEDIATE CAUSE (Final disease or condition resulting in death) A CUTE Breach Chospan Due to (or as a consequence of): CHRONC OBSTRUCTURE PULMONTHY DISEASE YEARS DUE TO (OR AS A CONSEQUENCE OF): Due to (or as a consequence of): CHRONC OBSTRUCTURE PULMONTHY DISEASE YEARS DUE TO (OR AS A CONSEQUENCE OF): Due to (or as a consequence of): Due to (or as a consequence of):												
	PART II. Other algnificant conditions contributing to deeth but not resulting in					tha underlying cause given in Part			PERFO	YES 2 NO OF		WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF OEATH? 1 YES 2 NO	
N: W	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO W UNCERTAIN												
ICIA	25. WAS CASE REFERRED TO MEDICAL EXAMINER? Check only one) OTHER:												
PHYSICIAN:	1 U YES 2 NO 1 Inpetient 2 ER/Outpetient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. MANNER OF DEATH 28a. DATE OF INJURY 28b. TIME OF 28c. INJURY AT 28d. DESCRIBE HOW INJURY OCCURED												
ВУ Р	(Month, Day, Year) INJURY WORK?						YES 2						
	3 Suicide 8 Could not be determined 28s. PLACE OF INJURY — At home, farm, atra building, atc. (Specify)					et, factory, office 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
COMPLETED	29s. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. 2 MEDICAL EXAMINER: On the basic of exemination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(e) and manner as stated.												
TO BE C	296. SIGNATURE AND TITLE OF CERTIFIER Maurice Meemo D38690 (Monthly Day, Year) 11/24/95												
F	30. NAME AND ADDRESS OF PERSON WHO CAMPLETED CAUSE OF DEATH (ITEM 27) (Typo, Print) MAUNICE COPPET 1030 & B BALLID NATIONAL PIKE ECZIOR												
	31, DATE FILED (Month, Day, Year) 32, BEGISTRAR'S SIGNATURE												
	NOV 2 7 1995	Juliad	wolson	arball									

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TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR STATE REGISTRAR

1

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

	1. DECEDENT'S NAME (First, Middle, Last)		0-	1			2. DATE OF DEATH	AV V	3. TIME OF DEATH	
	LANRE	NCE	GRI	MES			NOVEMBER 27-1995 3.20			
	A STATE OF THE STA		(In yrs. last birth	MONTHS	DAYS	IF UNDER 24 HRS	7. DATE OF BIRTN (Month, Day, Year)	8.	BIRTHPLACE (State or Foreign Country)	
			1 1	RS.	unts	HOURS WIN.	12/8/33	V.	A.	
m	FACILITY NAME (If not institution, give street		≪	9b. CITY,	0/	R LOCATION OF	DEATH	9c. COUNTY		
Ď	RESIDENCE OF DECEDENT	YAND TTO	SPITAL		1/1	NIDN		PRIN	DER GEONDES	
DIRECTOR	10a. STATE 10b. CDUNTY		100	c. CITY, TOWN O	R LOCAT	ION			10d. INSIDE CITY	
=	MD P.G.			Forest	vi:	lle			1 YES 2 NO	
A P	10e. STREET AND NUMBER				101.	ZIP CODE		10g. CITIZEN	OF WHAT COUNTRY?	
E	6839 Red Maple	Ct.			20	0747		U.S	.A.	
FUNERAL		FORCES? 1 X YES	N U.S. ARMED	13. V	AS DEC	ENDENT OF NISF	ANIC ORIGIN? (Specify Yes	or No- 14.	RACE — American Indian, Black, White, etc.	
Β¥	1 Never Married 2 Married 3 Wildowed 4 Millioniced	IF YES, GIVE WAR OR D	DATES			2 ND Spe		D	Specify:	
	15. DECEDENT'S EDUCAT	1956 1957		NT'S USUAL OC	CUPATIO	· · · · · · · · · · · · · · · · · · ·	16b, KIND OF BU		lack	
COMPLETED	(Specify only highest grade con Elementary/Secondary (0-12)	npleted) College (1-4 or 5+)	(Give kin	nd of work done d IOT use retired.)	uring mos	st of working	TOD. KIND OF BO.	SINESS/INDUS I	NY .	
P.	12	50110g5 (1-4 01 5 7)	Food	Attend	lan	t Supe	rvisor	Priva	te	
S S	17. FATHER'S NAME (First, Middle, Last)		-				AME (First, Middle, Maiden	Surname)		
BE (unknown					Ruth	L. Grimes			
0	19a. INFORMANT'S NAME (Type/Print)		19b. MA	ILING ADDRESS	(Street a	nd Number or Run	al Route Number, City or Tow	n, State, Zip Coo	(a)	
-	Sheila Grimes		0.83	y ked	Maj	ore Ct	.Forestvi	TIE,MC	1.20/4/	
	20a, METHOD OF DISPOSITION 1. □ Buriel 2 □ Cremetion 3 □ Remove		metery cremeter	ATE OF DISPOSI y or other place)			1	CATION — City		
	4 Donation 8 Other (Specify)		D. Ve				Y 12/4/95 FACILITY Hodge		tenham, Md.	
	· panice En		1	1	AME AN	D ADDRESS OF	nouge	s and	Edwards	
\vdash				39	910	Silve	r Hill Rd	.Suit	land,Md.	
	23. PART I. Entar the diseases, or com ahock, or heart fellure. List	nofications that cause t only poe couse on e	d tha deeth. each line.	Do not enter	the mod	de of dying, s	ich aa cerdiac or reapi	ratory arreat,	Approximate Interval Between	
	iMMEDIATE CAUSE (Finel disease or condition	Bilat	Bril	and	2-1	motion	Kan	4.41	Onset and Death	
	resulting in death)	DUE TO (OR AS	A CONSEQUEN	CE DEL	71	maj	- Irna	mor	real Injohn	
2		516	1	Dul	u	Je	du		1 Mon	
[일	Sequentially list conditions, if any, leading to immediate	DUE TO OR AS	A CONSEQUEN	CE gir)		T	5		61.00	
2	cause. Enter UNDERLYING CAUSE (Disease or Injury	Aca	to	Len	4				11/1.	
造	that initiated events resulting in death) LAST	OUR 10 (OR AS	CONSEQUEN	COFICER:	0	1 11.	0.		2000	
CERTIFICATION	C 4_	Clen	ent	2,0	16	1 31	rone		19/	
	PART II. Other significant conditions of	ontributing to death i	out not result	ting in the unc	terlying	csuse given	n Part I. 24s. WAS AN		24b. WERE AUTOPSY FINDINGS	
MEDICAL							PERFOR	. /	AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?	
ME									1 TES 2 NO	
ä	DID TOBACCO USE CONTRIB	BUTE TO CAUSE C	OF DEATH	YES 🗆 N	10 1	UNCERTA	IN 🔲			
PHYSICIAN:		OSPITAL:		OTHER	-					
ΥS	1 YES 2 NO 1	Inpatient 2 ER/Out		OA 4 Numi	ng Home		6 Other (Specify)			
	1 Netural 5 Pending	(Month, Day, Year)	250	NJURY	28c. INJL WOI	DRY AT RK? ES 2 ND	28d. DESCRIBE HOW II	NJURY OCCURE	ED	
ВУ	2 Accident trivestigation 3 Suicide 8 Could not be	28a. PLACE OF INJURY	f At home, fa	erm, street, facto			281, LOCATION (Street a	and Number or B	hural Brude Number	
TEO .	8 Could not be 4 Nomicide determined	building, etc. (Spe	cify)				City or Town, State)		and rouse realition,	
LE I	29a. CERTIFIER 1 CERTIFYING PHYSICIAL	N: To the best of my know	riedge, death or	coursed at the tir	ne dete	and place, and d	ue to the cause(a) and mer	nor on stated		
COMPLET									use(s) and menner as stated.	
	290. SCHATURE AND FITCH OF CERTIFIER		11	1/_		29e: LICENSE N			SNED (Month, Day, Year)	
BE	husen	TMD	40	lud	ui 1	1 - 7	4535	> /	1/27/45	
2	30. NAME AND ADDRESS OF PERSON WHO C	OMPLETED CAUSE OF DE			1	() "	7 1 - 1		1 - 110	
	LAXMI BERWA	7700 0	ed br	LANCH	Ine.	nu. C	Centon	Mony	Cana 2072-	
	31. DATE FILED (Month, Day, Year)	32. RESISTRAR'S SIGN		10						
	DEC = 4'1995	Juna	SEE PERM	14						

the Marine Sent Marie .

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the bospital or attending physician.

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IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

	FOR 1 - STATE REGISTRAR	STATE OF MARYL	AND / DEPART	MENT OF H	EALTH AND I	MENTAL	HYGIENE REG. NO.			
	1. DECEDENT'S NAME (First, Middle, Last) RUBELT	ELMER GIBSO				2. DATE O	of DEATH	194		7:17 A M
	4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE	(In yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE 0	F BIRTH Day, Year)	8.		ACE (State or Foreign
	219-34-9579	44	55 YRS.	MONTHS DAYS	HOURS MIN.		8, 19			Land
-	9e. FACILITY NAME (If not institution, give				R LOCATION OF DE	HTA		9c, COUNTY	OF DEA	тн
DIRECTOR	Holy Cross Hospi	tal		Silver	Spring			Montg	omer	У
	10e. STATE 10b. COUNT	Υ	10c. CITY,	TOWN OR LOCAT	ON				1	0d. INSIDE CITY LIMITS?
	Maryland Mo	ntgomery	K	ensingto	on				1	YES 2 NO
FUNERAL	10e. STREET AND NUMBER	_		101.	ZIP CODE	_		10g. CITIZEI		AT COUNTRY?
NE I	3007 Jennings Ro				2089				US	
BY FU	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER I FORCES? 1 YES IF YES, GIVE WAR OR D	2 X NO	If yes, spe	ENDENT OF HISPAN city Cuban, Mexica 2 M NO Specifi	n, Puerto R		or No.— 14	Black, \ Specify:	- American Indian, White, etc. White
ETED	15. DECEDENT'S EDU (Specify only highest grade	ICATION COMPONENTS	16a. DECEDENT'S U	ISUAL OCCUPATIO		16b.	KIND OF BUS	INESS/INDUS	TRY	WILLE
Ш	Elementary/Secondary (0-12)	College (1-4 or 5+)	life. Do NOT use	retired.)	n or worning					
COMPL	12		Courie	r			rivate			
	17. FATHER'S NAME (First, Middle, Last) Lawrence E. Gibs	0.77			18. MOTHER'S NA			Surname)		
M	19a. INFORMANT'S NAME (Type/Print)	OII	40h MAII INC	DODECC /Street	Jessi			0 - 7 - 0	ed S	
일	Linda A. Gibson				Road, K					Sec. Sec.
	20s. METHOD OF DISPOSITION	20	b. PLACE AND DATE O	F DISPOSITION (Na	me of	DATE	_	CATION — CIT		n, State
	1 😡 Burlel 2 🗆 Cremation 3 🗔 Ren 4 🗋 Donation 5 🗔 Other (Specify)	Toval from State cer	retery, crematory or oth Ft. Linco	in Cemet	ery 12	/9/95	Brei	ntwood	,	MD
	21. SIGNATURE OF FUNERAL SERVICE LI	Chipak		Franc	o adoress of facis J. Co Jniversi	ollin				
ERTIFICATION	23. PART I. Enter the diseases, or shock, or heart fellure. IMMEDIATE CAUSE (Finel disease or condition resulting in death) Sequentially liet conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initieted events resulting in deeth) LAST	a. DUE TO (OR AS DUE TO (OR AS C.	eech line.	diol I			lac or respli	story srres	t,	Approximate Interval Between Onset and Death /2 hour
MEDICAL C	PART II. Other algorificent condition Hyperkos, m DID TOBACCO USE CONT					_	24a. WAS AN PERFOR	MED?	0	VERE AUTOPSY FINDINGS MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? YES 2 NO
SICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?		26. PLACE OF DEAT	H (Check only one)						
Si	1 YES 2 NO	HOSPITAL: 1 Inpetient 2 ER/Out	patient 3 XDOA	OTHER: 4 Nursing Hom	e 5 🗆 Realdenca	8 🗆 Other	(Specify)			
PH	27. MANNER OF DEATH 1 Netural 5 Pending	28a. DATE OF INJURY (Month, Day, Year)	26b. TIME	JRY WO	RK?	28d. DES	CRIBE HOW II	NJURY OCCU	RED	
B	2 Accident Investigation	280. PLACE OF INJUR	Y At home town of		ES 2 NO		TION (C)		0	
	3 Suicide 5 Could not be 4 Homicide datermined	building, etc. (Spe	ecify)	treet, fectory, offic			ATION (Street a or Town, State)	nd Number or	Hunsi Ho	ute Number,
COMPLE	onel	SICIAN: To the best of my know								and manner as ateted.
9E	29b. SIGNATURE IND TITLE OF PRTIFIL	MD MD			D 21	MBER 340		≥ Dec	IGNED (Month, Day, Year)
0		HO COMPLETED CAUSE OF DISAUSE 394	EATH (ITEM 27) (Type,		R W	Hear	TON.	MD	20	4006
	31. DATE FILED (Month, Day, Year) DEC 08 1995	Julia divusario	NATURE							

DIVISION OF VITAL RECORDS, P.O. BOX 68760

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	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within at hours after death. Page 6 may be retained by the hosp	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: if Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE	0F		/ DEPARTMENT				MENTAL	HYGIENE
		C	ERTIFICATE	0	F DEAT	ГН		REG. NO.

	1 - STATE REGISTRAR	STATE OF MARYL	AND / DEPAR CERTIF	RTMEN	T OF H	DEA	AND	MENT	AL HYGIE				
	1. DECEDENT'S NAME (First, Middle, Last)			10/11/		DLA			E OF DEATH		_	3. TIME OF DEA	гн
		William R. G	emma					Dec	cember	2. T	YEAR 995	3:20	Ам
	4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE	(in yrs. last birthday)	IF UNDER		IF UNDER	24 HRS.	7. DAT	E OF BIRTH	2/ 1	& BIRTI	HPLACE (State or Fo	
	027-24-4307	1 <u>№</u> M 2 🗆 F 6	3 YRS.	MONTHS	DAYS	HOURS	MIN.	Jur	nth, Day, Year) 1e 9, 1	L932	Mas	m) sachuset	ts
	9a. FACILITY NAME (If not institution, give	street and number)		9b. CITY	r, TOWN C	R LOCATI	ON OF D	_		~	UNTY OF C		
DIRECTOR	11305 Berger Ter	race			Pot	omac				Мо	ntgo	gomery	
SE .	10a. STATE 10b. COUNT	TY	10c. CIT	TY, TOWN	OR LOCAT	ION						10d, INSIDE CITY	
		tgomery		Pot	omac							LIMITS?	NO
FUNERAL	100. STREET AND NUMBER				101	. ZIP COD						WHAT COUNTRY?	
NE	11305 Berger Ter					208					ited	States	
BY FU	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IF FORCES? 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	2 NO								E — American India k, White, etc.		
G	15. DECEDENT'S EDU (Specify only highest grade	JCATION	16a. DECEDENT'S	USUAL O	CCUPATIO	ON .		16	b. KIND OF BI	JSINESS/IN	DUSTRY		
COMPLETED	Elementary/Secondary (0-12)	College (1-4 or 5+)	life. Do NOT u	(Give kind of work done during most of working life. Do NOT use retired.)									
MP		5+	Exec	Executive						Lth C	are		
8	17. FATHER'S NAME (First, Middle, Last)			18, MOTHER'S N									
BE	Salvatore Jam	es Gemma		Jessie 19b. MAILING ADDRESS (Street and Number or Rural Route						h Br	acke	tt	
ဥ	19a. INFORMANT'S NAME (Type/Print)												
	Dianna P. Gemma					_	_		comac,	Mary	land	20854	
	20a. METHOD OF DISPOSITION 1 💢 Burisl 2 🗆 Cremation 3 🗆 Rem 4 🗆 Donation 5 🗀 Other (Specify)	noval from State 201	netery, crematory or or netery.	of Dispos	De	c. 8	, 19	95 DA	TE 20c. L	cation -		_{own, State} Virginia	
	21. SIGNATURE OF FUNERAL SERVICE LI		I I I I I I I I I I I I I I I I I I I	22.	NAME AN	D ADDRE	SS OF FA	CILITY					
	23. PART I. Enter the diseases, or	and	M00198		300 Rock	West	Mon	tgon	nery Av	zenue 1850-	2805	/Rockvil I	le, nc.
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	c	A CONSEQUENCE OF	DIAL IN FARCONSEQUENCE OF): ONSEQUENCE OF): ONSEQUENCE OF):						156	AS E	Donest and Accord	
PHYSICIAN: MEDICAL CI	PART II. Other algorificant condition	ns contributing to deeth b	out not resulting	in the ur	ndertylng	ceuse (given in	Part I.	24s. WAS AI PERFO 1 TYES	RMED?	246	WERE AUTOPSY FI AMAILABLE PRIOR COMPLETION OF CO OF DEATH? 1 YES 2	AUSE
Z	DID TOBACCO USE CONT	RIBUTE TO CAUSE C	F DEATH YE	ES 🔲 I	NO [UNC	ERTAI	N D	1				
5	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 VES 2 NO	HOSPITAL:	26. PLACE OF DEA	OTHER	R:		_						
Ë	27. MANNER OF DEATH	1 Inpatient 2 ER/Out	28b, TIM		aing Hom 28c. INJ		aldence		er (Specify)	IN ILIEN OC	CUREO		
ВУР	1 Netural 5 Pending 2 Accident Investigation	(Month, Day, Year)	INJ	M	WO		NO	200. 00	SOMBE NOW	INJUNT OC	LUNEU		
	3 Suicide 6 Could not be determined	28s. PLACE OF INJURY building, etc. (Spec	— Al home, lerm, :	streel, lact	ory, office	1		20f. LO City	CATION (Street y or Town, Statu	and Numbe	or or Rural F	Route Number,	
3 Suicide Could not be detarmined Suicide Suicide City or Town, State) 296. LOCATION (Street and Number or Rural Route Num City or Town, State) 296. CERTIFIER (Check only one) City or Town, State) 296. LOCATION (Street and Number or Rural Route Num City or Town, State) 297. LOCATION (Street and Number or Rural Route Num City or Town, State) 298. CERTIFIER (Check only one) City or Town, State) 298. CERTIFIER (Check only one) City or Town, State) 298. CERTIFIER (Check only one) City or Town, State) 298. CERTIFIER (Check only one) City or Town, State) 298. CERTIFIER (Check only one) City or Town, State) 298. CERTIFIER (Check only one) City or Town, State) 298. CERTIFIER (Check only one) City or Town, State) 298. CERTIFIER (Check only one) City or Town, State) 298. CERTIFIER (Check only one) City or Town, State) 298. CERTIFIER (Check only one) City or Town, State) 298. CERTIFIER (Check only one) City or Town, State) 298. CERTIFIER (Check only one) City or Town, State) 298. CERTIFIER (Check only one) City or Town, State) 298. CERTIFIER (Check only one) 298. CERTIFIER (Check one) 298. CERTIFIER (Check one) 298. CERTIFIER (Check one) 2											Contract Con	eled.	
IO BE	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Francis C. Mayle, Jr., M.D. 10215 Fernwood Road, Bethesda, Maryland 20817												
				ernwo	ood 1	Road	Be	thes	da, Ma	ryla	nd 2	20817	
	DEC 07 1995	AFGISTAR'S SIGN	ANDE										

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TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 74 hours after death. Page 6 may be retained by the hospital on requires that the death certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunia-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept of Health and Mental Hygiene prior to burial, cremation, or removal.

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	FOR STATE REGISTRAR	STATE OF MARY		MENT OF H		MENTAL HYGIENI REG. NO.	E			
	1. DECEDENT'S NAME (First, Middle, Last)					2, DATE OF GEATH			3. TIME OF DEATH	
,	Virgi	inia Lee Gro	ssman			December		YEAR	7:15 A M	
	4. SOCIAL SECURITY HUMBER		GE (In yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH		BIRTH	PLACE (State or Foreign	
	220-16-3501	1 🗆 M 2 🔯 F	71 YRS.	MONTHS DAYS	HOURS MIN.	Jan. 11, 1	924	Country	t Virginia	
	9a. FACILITY NAME (If not institution, give :	street and number)	/1	9b. CITY, TOWN	OR LOCATION OF DE		9c. COUNTY OF DEATH			
œ	Holy Cross Hosp		100		Spring		Montgomery			
DIRECTOR	RESIDENCE OF DECEDENT							0		
Ä	10a. STATE 10b. COUNT	Y	10c. CITY	TOWN OR LOCA	ПОН				10d. INSIDE CITY LIMITS?	
ā	Maryland Mon	ntgomery		Kensi	ngton				1 TES 2 HO	
A	10e. STREET AHD NUMBER		•	10	. ZIP COOE		10g. CITIZE	EN OF W	HAT COUNTRY?	
	3003 Fayette	e Road			20895		Unit	ed	States	
FUNERAL	11. MARITAL STATUS	12. WAS DECEDENT EVE				HC ORIGIN? (Specify Yea		4. RACE	- American Indian.	
_	1 Hever Married 2 Married	FORCES? 1 YE			ecify Cuban, Mexica 2 😾 HO Specify	n, Puarto Rican, etc.)		Speci		
BY	3 🙀 Widowed 4 🗌 Divorced	<u> </u>							White	
	15. DECEDENT'S EDU (Specify only highest grade	JCATIOH le completed)	16a. DECEDENT'S U	JSUAL OCCUPATI		16b. KIHD OF BUS	IHESS/IHDU	STRY		
<u> </u>	Elementary/Secondary (0-12)	College (1-4 or 5 +)	life. Do NOT use	retired.)						
릊ㅣ	12		Homema	ker		<i>N</i> O	n Hon	ne		
COMPLET	17. FATHER'S HAME (First, Middle, Last)				18. MOTHER'S NA	ME (First, Middle, Malden	Surname)			
ш	Guy O. Barker				Iva	Mae Strobr	idge			
10 B	19a. INFORMANT'S NAME (Type/Print)		19b. MAJLING	ADDRESS (Street	and Number or Rural i	Route Number, City or Town	, State, Zip C	Code)		
F	Harry J. Grossman	n, Jr.	13724	Hobart	Drive, S	Silver Spri	ng, M	ID	20904	
	20a. METHOD OF DISPOSITION 1 St Burlel 2 ☐ Cremation 3 ☐ Rem		20b. PLACE AND DATE O			1995 20c. LO	CATION — CI	lty or To	wn, State	
	4 Donation 5 Other (Specify)	HOVER HOILI STATE	cemetery, crematory or oth Parklawn	Memoria	Imper _k 4,	Roc	kville	e, N	faryland	
	21. SIGNATURE OF FUNERAL SERVICE LI	ICENSEE		22. HAME A	HD ADDRESS OF FA	CILITY	ol Ho	/	Doglessi 11a	
	De Auli	100	M00198	300 1	Vest Mont	hrey Funer gomery Aye	nue		Inc.	
	23. PART I. Enter the diseases, or	complications that cau	end the death. Do n	_ L Rock	ville. Ma	aryland 20	<u> 1850-2</u>		I Assessment	
	shock, or heart fellure.	. List only one cause or	n each line.	or enter the inc	rae or aying, adc	il as caluisc or leap	ratory arre-	ert,	Approximate Intervsi Between	
	IMMEDIATE CAUSE (Final disease or condition	0							Onset and Death	
	resulting in desth)	· Sep	S 1 S							
		0 .								
8	Sequentially list conditions,	a Hbd	S A COHSEQUENCE OF	savel.	petora	tion				
Ě	if sny, lesding to immediate cause, Enter UNDERLYING				•					
RTIFICATION	CAUSE (Disease or injury	C. DUE TO (OR (S & SYN	drome						
Ē	that initiated events resulting in death) LAST		netoid a						İ	
CEL		d. Kreur	netold a.	TINVIT	7				+	
AL	PART II. Other significant condition	ns contributing to deat	h but not resulting in	n the underlyin	g csuse given in			24b	WERE AUTOPSY FIHDINGS	
<u>ଧ</u>	neutro	penia -c	hanse			1 YES 2			AVAILABLE PRIOR TO COMPLETION OF CAUSE	
EDIC							M uo		OF DEATH?	
Σ	DID TOBACCO USE CONT	FRIRLITE TO CAUSE	OF DEATH YE	S NO [UNCERTAI	ND			I LES LIXINO	
A	25. WAS CASE REFERRED TO MEDICAL	T CAUSE	28. PLACE OF DEAT							
HYSICIAN:	EXAMIHER?	HOSPITAL:	N.4	OTHER:	- 07-111	- 17 - 17 - 17				
₹	27, MANHER OF DEATH	28s. DATE OF IHJUI			IURY AT	8 Other (Specify) 28d. DESCRIBE HOW II	A ILIBY OCCI	IRED		
٥١	1 Netural 5 Pending	(Month, Day, Yee			ORK?	200. DESCRIBE NOW I	TOOK! OOD	JUED		
B	2 Accident Investigation		URY — At home, ferm, s			281, LOCATION (Street a	and thembor o	or Ownell	Pouto Alumber	
	3 Suicide 8 Could not be 4 Homicide determined	building, atc. (S		irees, tactory, orm		City or Town, State)	Ind Namber 0	n nurer r	todie Number,	
	an complete	l								
MPLET	0001	SICIAH: To the best of my ki								
8	one) 2 MEDICAL EXAMIH	IER: On the basis of examin	ation end/or investigation	n, in my opinion,	death occured at the	time, data and place, an	d dua to the	ceuse(s	end manner as stated.	
w I	296. SIGNATURE AND TURE OF CERTIFIE	ER /			29c. LICEHSE HUI	MBER	29d. DATE	SIGHED	(Month, Day, Year)	
m	Lande A	1/Sum.	lar		D359	96	> /	2 -	1-95	
임	30. HAME AND ADDRESS OF PERSON W	HO COMPLETED CAUSE OF	DEATH (ITEM 27) (Type,	Print)	2007	1 4				
	LINDA M BUI	ADEIL MID	, 2101 Me	NI P	. Da 12	#201. 514		0.0	10 MAD	
	31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S S	IGHATURE	UICALIAN	DRIVE	25 , 0/4	CACI	MI	20902	
	DEC 04 1995	Jalin Davidson	Restall							
	1000	/								

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within Z4 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

FOR STATE OF MADVIAND / DEPARTMENT OF HEALTH AND MENTAL HYCIENE

	1 - STATE REGISTRAR	SINIE OF MIN	CE			OF DEA			REG. NO.				
	1. DECEDENT'S NAME (First, Middle, Last)							2. DATE OF	OEATN		MEAN	3. TIME OF OEAT	Ή
		Vartouhi	Ghazari	ian				Decen			995	10:37	Рм
	4. SOCIAL SECURITY NUMBER	5. SEX 6.	AGE (In yrs. last	birthday)	IF UNDER 1 Y			7. DATE OF (Month, E	BIRTH			IPLACE (State or Fo	reign
	216-80-5967	1 🗌 M 2 🔀 F	81	YRS.	MONTHS DA	HOURS	MIN.	May 2	3, 1	914		rkey	
	9e. FACILITY NAME (If not institution, give str	reet and number)			9b. CITY, TO	WN OR LOCATI	ON OF DE				INTY OF D	EATH	
DIRECTOR	Holy Cross Hospi	ital			S	ilver	Spri	ng		Mo	ntgor	nery	
ַלַ	RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY	,		10a CIT	Y, TOWN OR L	OCATION						10d. INSIDE CITY	
<u>E</u>	100	gomery		100. 011		kville						LIMITS?	
	10e. STREET AND NUMBER	gomery			ROC	10f, ZIP COD	F			10a CII	TIZEN OF V	1 TYES 2 XX	NU
FUNERAL	10401 Grosvenor	Place #5	06			208						States	
N I	11. MARITAL STATUS	12. WAS DECEDENT E	VER IN U.S. ARM		13. WAS	DECENDENT		NIC ORIGIN? (Specify Yes		14, RACE	E - American Indi	en,
	1 Never Married 2 Merried	FORCES? 1 []		0		s, specify Cube YES 2 XNO			en, etc.)		Black	k, White, etc.	
ВУ	3 K Widowed 4 Divorced											White	
LED	15. DECEDENT'S EDUC (Specify only highest grade		(Gh	re kind of	USUAL OCCU	PATION g most of worki	ng	16b, K	IND OF BU	SINESS/IN	DUSTRY		
Ш	Elementary/Secondery (0-12)	College (1-4 or 5+)	life.		se retired.)					••			
COMPLET	1.2 17. FATHER'S NAME (First, Middle, Last)		<u> </u>	Hom	emaker					Hom	e		
	Kevork Khakhami	an						ME (First, Mid itza A					
BE	19e. INFORMANT'S NAME (Type/Print)	Lan	19h	MARINO	ADDRESS /S	reet end Numbe					in Code)		
2	Kevork Ghazarian					enor P						MD 20852	
	20e. METNOD OF DISPOSITION					ec. 6,			_		- City or To		
	1 1 Burlel 2 □ Cremation 3 □ Remo	oval from State	Gate of	of H	ether plece) D eaven	ec. 6, Cemete	199: rv	5	Sil	ver	Spri	ng, Mary	land
	21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEE			00 1141	AE AND ACCOR	00 05 54	CILITY			•		
	*Kalul Fa	and	M(019	8 755	Beth	esda	-Chevy	Cha	se,	Inc.	/ 20814-3	501
	23. PART L Entar the piseasea, or o	complications that c	aused the dea	ath. Do	not enter the	mode of dy	ing, suc	h aa cardla	c or reep	Iratory a	rreat,	Approxim	ata
	shock, of hasrt fallura. I				1 12							Onaat and	
	disease or condition resulting in death)	Acut	C-014	me	shi.	011	les.	tear	5			lead	en
	reauting in death)	DUE TO (OI	R AS A CONSEC	UENCE C	F):	7	000						
N	Sequantially list conditions,	b											
CERTIFICATION	If any, leading to immediate cause. Enter UNDERLYING	DUE TO (OI	R AS A CONSEO	UENCE O	F):								
5	CAUSE (Diseasa or Injury	DUE TO (OI	R AS A CONSEO	UENCE C	fi:					_		_	
E	reaulting in death) LAST	_											
S		o											
EDICAL	PART II. Other algolificant condition	s contributing to da	ath but not re	sulting	In the unde	rlying cause	given in	Part I. 2	4s. WAS AN PERFOR		24b	AWAILABLE PRIOR	10
ğ								— l¹	YES 2	NO NO		COMPLETION OF OF DEATH?	CAUSE
Σ	DID TODA CCO LICE CONT	DIDLITE TO CALL	CE OF DEAT	PLI V			CERTAN					1 - YES 2 1	NO
AN	DID TOBACCO USE CONTI	KIBUTE TO CAU			TH (Check only		CERTAII	иП					
SICIAN:	EXAMINER?	HOSPITAL:	/		OTHER:								
PHYS	27. MANNER OF DEATH	26e. DATE OF IN		26b. TII		Nome 5 R	esidence	28d, DESCI		INJURY O	CCURED		
	1 Natural 5 Pending	(Month, Day,	Year)	IN	JURY M	WORK?	NO						
D BY	2 Accident Investigation 3 Suicide 6 Could not be	26e. PLACE OF II building, etc	NJURY — At hor	me, term,	street, lectory	office		28t. LOCAT	ION (Street	and Numbe	er or Rural	Route Number,	
ш	4 Homicide determined	Contains, the	a (Opecity)					City or	Town, Stete)	,			
PLE	290. CERTIFIER 1 CERTIFYING PHYSI	CIAN: To the best of my	y knowledge, de	nth occur	red at the time	, date end plac	e, end due	to the cause	e(e) end ma	nner ee st	ated.		
COMPLET	one) 2 MEDICAL EXAMINE	R: On the beele of exam	ninstion end/or i	rivestigati	on, in my opin	ion, death occu	red et the	time, date e	nd place, er	nd due to	the couse(e) end manner ee i	risted.
ПС	29b. SIGNATURE AND THE OF CERTIFIE	9					ENSE NUI			29d. DA	TE SIGNED	O (Mopth, Day, Year)	
m	MARAMALE	auger, N	1. D.			Do	288	34		1	2/3	3/95	
5	30. NAME AND ADDRESS OF PERSON WH	O COMPLETED CAUSE				4.		1:1-	2			40	200
	NARRY ROSENBA	UM 37		ARA	RAGUT	- AVE	. /	KENS	ING	070	4,11	0 200	75
	31. DATE FILED (Month, Day, Year) DEC 04 1995		S SIGNATURE										
	I DEL'HATIUUL	HELPA OTHER	war have	2.5									

permit. Pages 1, 2, 3 burial-transit retained by the hospital or attending physician. the 18 use for detached 2 director, page 5 should after death. Page 6 may be funeral filled in by the fion. or removal. hours 6 cremation. completely requires that the death certificate be executed n and con to burial. attending physician a artal Hygiene prior to the atter by the to been signed by pt. of Health and 3 shows any In

MARYLAND 21215-0020

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DIVISION OF VITAL

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Injury.

AL OR ATTENDING PHYSICIAN: The law red AL DIRECTOR: After this certificate has been 2 hours after death with the State Dept. of If Item 28 is marked, or Item 23 sh

FUNERAL within 72 h HOSPITAL

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IMPORTANT: If

CERTIFICATION

PHYSICIAN: MEDICAL

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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

FOR STATE REGISTRAR 1 -CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 3. TIME OF DEATN 2. DATE OF DEATN December 1 1995 James Columbus Garner, Sr. 2:00A 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. lest birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign September 28, 213-24-3998 65 DAYS 1 M 2 - F HOURS 1930 Maryland YRS. 9a. FACILITY NAME (If not institution, give street and number, 9b. CITY, TOWN OR LOCATION OF GEATN 9c. COUNTY OF CEATH DOCTORS COMMUNITY HOSPITAL LANHAM Prince Georges RESIDENCE OF DECEDENT 10a. BTATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Prince Georges Upper Marlboro 1X YES 2 NO 10e. STREET AND NUMBER 101. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 6110 Greenlanding Road 20772 U.S.A. 12. WAS DECEDENT EVER IN U.S. ARMEO FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-14. RACE — American Indian, Black, White, etc. tf yea, specify Cuban, Mexican, Puerto Rican, etc.)
t ☐ YES 2 ▼ NO Specify: 1 Never Merried 2 Married 3 Widowed 4 X Divorced White 15. OECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade complete (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) 10 Labor Agriculture 17. FATHER'S NAME (First, Middle, Last) 16. MOTNER'S NAME (First, Middle, Meiden Surname) James Roy Garner Florance Tayman 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) James Columbus Garner, Sr. Jr. 39547 Lindsey Way, Mechanicsville, MD 20659 20a. METNOD OF DISPOSITION
1 Burial 2 Cremation 3 Removat from State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State tery, cremetory or other piece) George Wash. 4 X Donation 5 Other (Specify) 12/1/95 Washington, DC Iniversity Med. H. SIGNATURE OF FUNERAL SERVICE LICENSEE Columbia Wortuary Services, Inc. 225 Missouri Avenue, NW, Washington, DC 20011 1CO 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart fellure. List only one ceuse on each line. Approximata Interval Between IMMEDIATE CAUSE (Final Onset and Death disease or condition resulting in deeth) DUE TO (OR AS A CONSEQUENCE OF): DAY Encaphlopathy Week Hepatic Sequentially list conditions. DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate cause. Enter UNDERLYING Alcablie Liver CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other aignificant conditions contributing to deeth but not resulting in the underlying ceuse given in Part I. 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS PERFORMED? AVAILABLE PRIOR TO COMPLETION OF CAUSE 1 TYES 2 NO OF DEATH? 1 TYES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL:
1 Inpatient 2 ER/Outpatient 3 DOA 1 YES 2 NO OTHER: 4 - Nursing Home 5 - Residence 8 - Other (Specify) 27. MANNER OF DEATN 28a, DATE OF INJURY 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d. DESCRIBE NOW INJURY OCCURED 1 Natural 5 Pending М 1 YES 2 NO Investigation 2 Accident 26e. PLACE OF INJURY — A1 home, term, streat, factory, offica building, atc. (Specify) 3 Sulcide 261. LOCATION (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 4 Nomicide TX CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated. 2 MEDICAL EXAMINER-OR the basis of exemination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated. DYSS (J 296. SIGNATURE AND TITLE OF CERTIFI 29d. DATE BIGNED (Month, Day, Year) MD 127-95 21 30. NAME AND ADDRESS OF PERSON WNO COMPLETED CAUSE OF DEATH (IVEM 27) (THE PRINT)

BOUCE MILE WILLE DE MD 20 32. REGISTRALE SIGNATURE 31. DATE FILED (Month, DEC

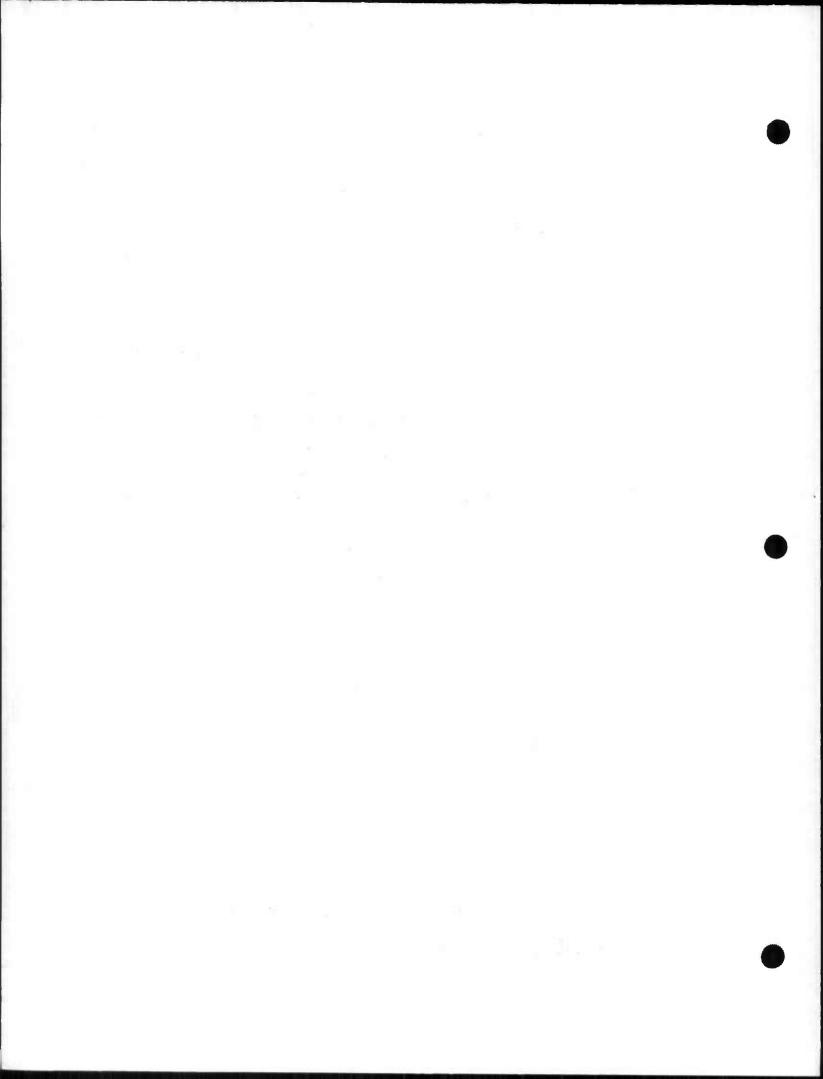
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TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

FOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

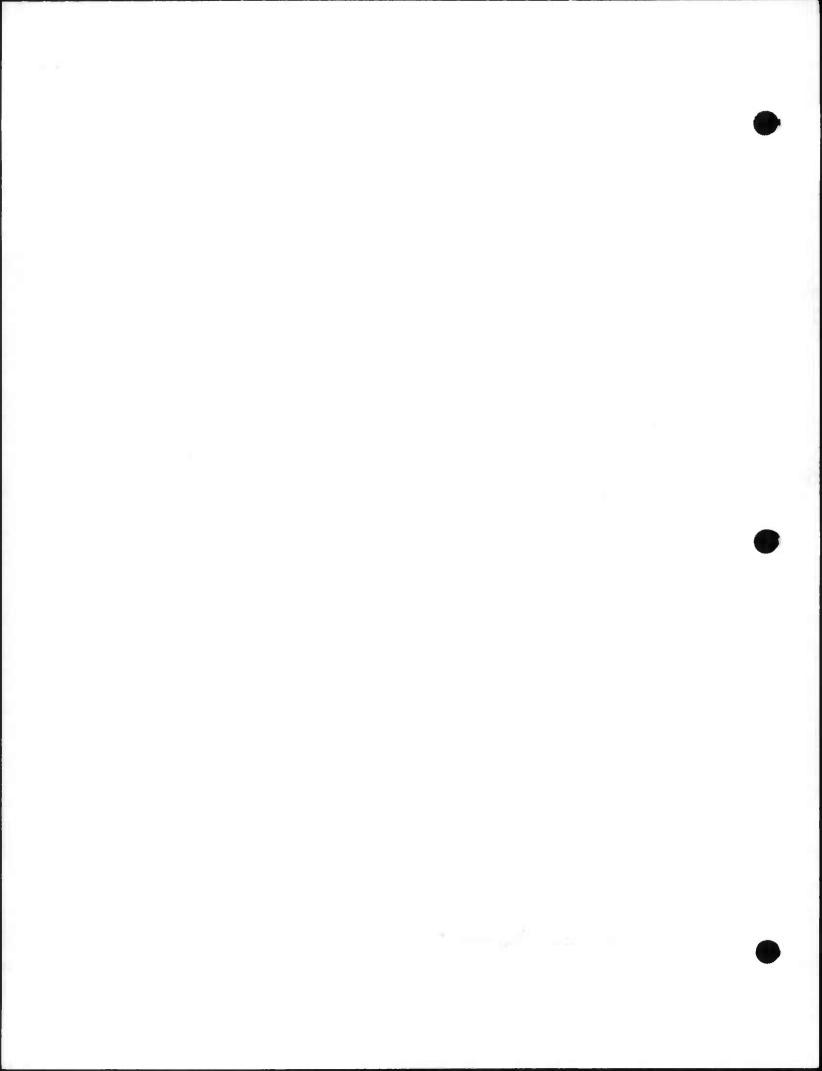
	1 - STATE REGISTRAR	CE	RTIF	ICATE OF	DEATH	REG. N	10.				
	1. DECEDENT'S NAME (First, Middle, Lest)		_			2. DATE OF DEATH	DAY 7 0 C	YEAR	3. TIME OF DEATH		
		RRAY		nnon		Nov. 30	199	95 EAR	9:23 A M		
	4. SOCIAL SECURITY NUMBER 220-26-8935 5. SEX 1 \square M 2 \square	6. AGE (In yrs. las	t birthday) YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year)		Countr	PLACE (State or Foreign y) RYLAND		
OR	9a. FACILITY NAME (if not institution, give atreet and number MEMORIAL HOSPITAL	7)			TON	EATH		ALBC			
DIRECTOR	10e. STATE 10b. COUNTY MARYLAND CAROL	INE		Y, TOWN OR LOCAT					10d. INSIDE CITY IMITS? 1 YES 2 NO		
FUNERAL	10e. STREET AND NUMBER 24354 BRIDGETOWN RO)AD	-	101	ZIP CODE 21	636	10g. CIT	USA	VHAT COUNTRY?		
ВУ	Naver Married 2 Married FORCES1	EDENT EVER IN U.S. AR 1 YES 2 N IVE WAR OR DATES		If yea, sp	ENDENT OF HISPA ecity Cuben, Mexic 2 NO Speci	NIC ORIGIN? (Specify an, Puerto Rican, atc.) fy:	Yea or No-	14. RACE Black Speci	E — American Indian, k, Whita, atc. #y: WHITE		
COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4)	(G	ive kind of Do NOT u		ON st of working	16b. KIND OF					
MP	17. FATHER'S NAME (First, Middle, Last)		HOU	SEWIFE	10 MOTHER'S N	AME (First, Middle, Mald	VN HO	ME			
ECC	WILLIAM J. MURRAY				The second second	RET ADR					
TO B	19a. INFORMANT'S NAME (Type/Print)					Route Number, City or					
F	BETTY G. RILEY		-		_		STEV		/ILLE, MD		
	20s_METHOD OF DISPOSITION 1	SPRIN		TLL CEN	ETERY	12-4 E	ASTON	I, MI			
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE	0.50		NEWNZ	M FUNE	RAL HOMI	E, P.	A.	N - MD		
CERTIFICATION	23. PART i. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Finel disease or condition resulting in deeth) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in deeth) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):										
MEDICAL	PART II. Other significant conditions contributions contributions contributed to the contribution of the contributions contributed to the contribute to the	re pulm	onar	y dise	ase	1 YES	AN AUTOPSY FORMED? S 2 X NO	(24k	D. WERE AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO		
CIAI	25. WAS CASE REFERRED TO MEDICAL EXAMINER?		CE OF DE	OTHER:							
BY PHYSICIAN:	1 ☐ YES 2 NO 1 Nopetier 27. MANNER OF DEATH 28a, DA	t 2 ER/Outpetient 3 TE OF INJURY onth, Day, Year)	28b. TII	4 Nursing Hor	JURY AT ORK?	8 Other (Specify) 28d. DESCRIBE HO	W INJURY O	CCURED			
ED	3 Suicide 28e. PL	ACE OF INJURY — At he idding, atc. (Specify)	ome, ferm,	atreat, factory, offic	:•	281. LOCATION (Str. City or Town, St		er or Rural	Route Number,		
COMPLET	(Uneck only				Ime, date and place, and due to the cause(e) and manner as stated, opinion, death occured at the time, date and place, and due 10 the cause(e) end menner as a				s) end menner as stated.		
TO BE C	29b. SIGNATURE AND TITLE OF CERTIFIER	dKi		29c. LICENSE NUMBER D47534 29d. DATE SIGNED (Month, Day, 1) 1//3 0/95							
É	WAFIK I. ZAKI, 920				N, MD 2	1629					
		HETDAR'S SIGNATURE									



1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

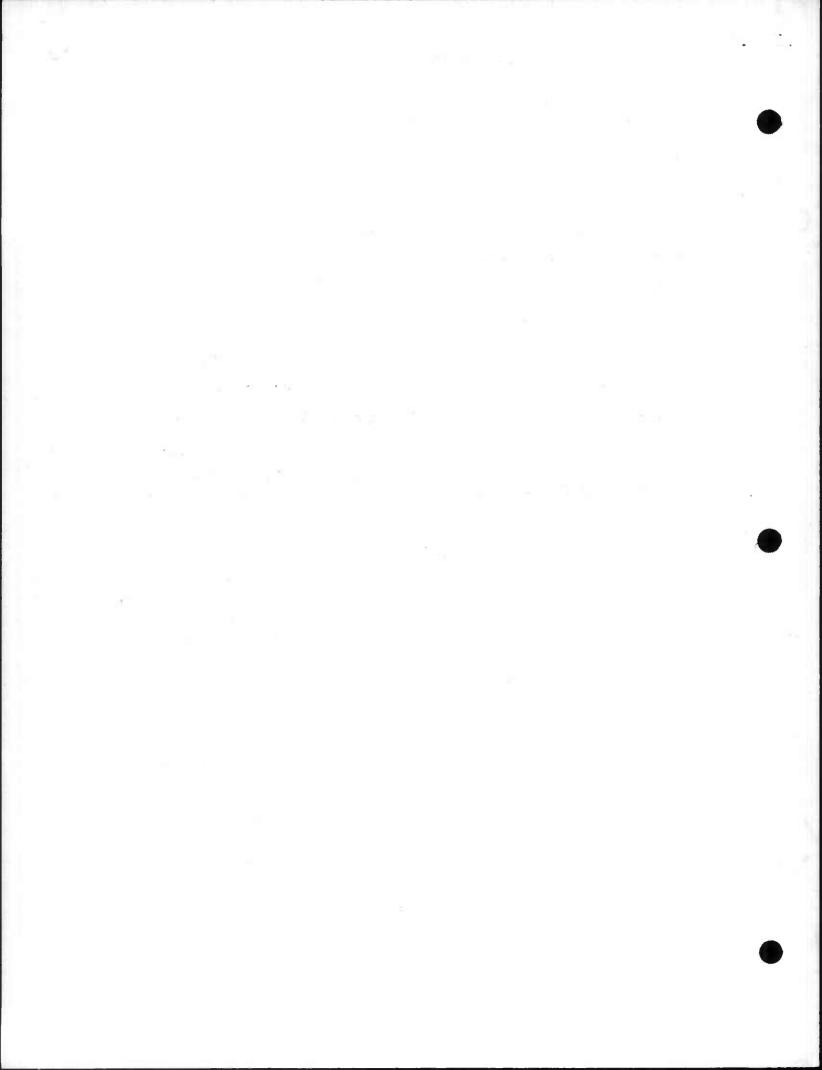
		1. DECEDENT'S NAME (First,	Atteletta I nati								1120.110	-		
											ATE OF DEATH	MY 1	EAR 3.	TIME OF DEATH
		DOROTHY	HAAK		dfe1						11	30 9	5	5.00am
		4. SOCIAL SECURITY NUMB	BER	5. SEX	6. AGE (In	yrs. last birthda			IF UNDER 24 HR	s. 7. D/	ATE OF BIRTH		BIRTHPLA	CE (State or Foreign
_	1 1	093-40-444	44	1 🗌 M 2 🟋	88	YRS	MONTHS	DAYS	HOURS MH	SE	PT.17,	1907	OHIC)
Should		9a. FACILITY NAME (If not in	stitution, give s	reet and number)			9h. CITY	/ TOWN	OR LOCATION O		11.1/	9c. COUNT		
\$5 67	Œ	WILLIAM II	TTT 17	ZAT DIL O	3 73 73					-				
2,	CTOR	WILLIAM H		EALTH C	ARE			EAS	TON			T	ALBO)T
2.	REC	10e. STATE	10b. COUNTY	,		10c. 0	ITY, TOWN	OR LOCA	ATION				100	I. INSIDE CITY
Pages	HE	MADVIAND		mat nom									2000	LIMITS?
permit.	1 1	MARYLAND 100. STREET AND NUMBER		TALBOT			<u>E.</u>	AST					12	YES 2 NO
<u> </u>	₩.							10	of, ZIP CODE			10g. CITIZE	N OF WHAT	COUNTRY?
020 physician. burial-transit	FUNERAL	501 DUTCH	MAN'S	LANE					216	01		U	SA	
020 physician. burial-trar	5	11. MARITAL STATUS		12. WAS DECEDEN	T EVER IN	U.S. ARMED	13.	WAS DE	CENDENT OF HIS	PANIC OR	IIGIN? (Specify Yes	s or No—	RACE -	American Indian,
		1 Never Married 2		FORCES? 1	WAR OR DAT	TES XNO			ipecity Cuban, Ma S 2X NO Sp		rto Rican, atc.)		Black, Wi Specify:	hita, etc.
1 声 中	B	3XXWidowed 4 Divo	rced						A	,-				HITE
affend use as	유		EDENT'S EDUC			16a. DECEDENT	'S USUAL O	CCUPAT	ION		16b. KIND OF BU	SINESS/INDUS	TRY	
		Elementary/Secondary (0	highest grade	College (1-4 or 8		(Give kind)	work done use retired.)	during m	nost of working					
a ge o		12	12)	A	"	IIO	псти	T 1315			OFFI	TOM		
the hospital or detached for u	COMPLET	17. FATHER'S NAME (First, M.	iddle (eat)	-11		но	USEW	TFE				HOME		
	5 5								18. MOTHER'S	NAME (Fi	rst, Middle, Maiden	Sumame)		
		ELLIS F.							EDI	TH	WARSTL	ER		
retained 5 should	TO BE	19a. INFORMANT'S NAME (7)	ype/Print)			19b. MAILI	O ADDRES	S (Street	and Number or Ru	iral Floute N	Number, City or Tow	rn, State, Zip Co	ode)	
2 2 0		CHARLES	E. WH	EELER		129	N. W	ASH	INGTON	I ST	FAS	TON.	MD	
2 2 2		20a. METHOD OF DISPOSIT	ION		20b. f	PLACE AND DAT						CATION - CIT		State
) w # 2		1 Donation 5 Other	(Specify)	oval from State	ceme	TCDIID	other place)	PACA	MODV	1		TODE	-	
- 4 - 3		21. SIONATURE OF FUNERAL		ENSEE	- DAL	TODUK	1 CR	NAME A	AND ADDRESS OF	FACILITY	1 SA	<u>L'ISBU</u>	RY,	MD
ALIIN death. Pag tuneral of											L HOME	D A		
		Nonc	1 2.	MERCE	ERZA	J CE	P 2	00	C HYD	DTC	ON ST.	FAC	mon.	MD
D. Dours after of in by the or removal		23. PART I. Enter tha di	seasea, or c	omplications the	t caused	the death. De	not enter	the m	ode of dying,	ouch as o	cerdiac or reap	ratory arrea	t.	Approximate
d in		ahock, or he	nart fallure. I	List only one cau	ise on eac	ch line.					E1 1120			Interval Batween
filled tion, or		IMMEDIATE CAUSE (Fin disease or condition	int	1	.1	10		1	, 20	100	/	. 0		Onset and Death
within pletely fille		resulting in death)	→ ,	· US	en	10	gene	ute	~ ~	CH	y record	47/4	sque	10422
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4 8 0 5	RTIFICATION	Sequentially list conditi if any, leading to immed		DUE TO	(OR AS A	CONSEQUENCE	OF):							
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eath certi		resulting in death) LAS	т 🌓											
- 6 5 -														
2 4 2 4		PART II. Other algnifice	nt condition	contributing to	death by	not regultin	Im the ur	derlylr	ng cause givan	In Part I	. 24s. WAS AN		24b. WE	RE AUTOPSY FINDINGS
2 2 5 5		ASAC	INTEH.	arus	l /2		him				PERFOR			ILABLE PRIOR TO IPLETION OF CAUSE
uires the signed Health a			V . 141	0.1	0	0.009	come				1 TYES 2	. No		DEATH?
requires een signe of Healtl													1 [YES 2 NO
e law request begin of 23 ches	AN:	DID TOBACCO U	SE CONTR	RIBUTE TO CA						AIN 🗆				1.1
		25. WAS CASE REFERRED TO EXAMINER?	MEDICAL		20	6. PLACE OF D)					
SICIAN: The certificate I the State	1 (7) [1	1 YES 2 W NO		HOSPITAL:	ER/Outpat	tient 3 🗆 DOA	OTHER 4 Nur	R: sing Nor	me 5 🗆 Rasiden	ce 6 🗆 0	Wher (Snectivi)			
SICIA certific	리수비	27. MANNER OF DEATH		26a. DATE OF	INJURY	28b. T	ME OF		JURY AT		DESCRIBE HOW I	NJURY OCCUR	RED	
NG PHYS			Pending	(Month, D	ay, Year)		NJURY	W	YES 2 NO				,,,,	
2 2 2 2		2 Accident					- "		169 2 100					
2 5 5 6			Investigation	20 - DI 40F 0	F 101 111 1001							and Number or	Rural Route	Mumber
ENDING PR: After ter death			Could not be	28a. PLACE O building,	F INJURY - atc. (Specif)	- At home, farm	, street, fact	ory, offic	ce	281. L	LOCATION (Street a City or Town, State)	III TYUTTIDA DI		rvarrioor,
TTENDI TOR: A after de	TED			28a. PLACE O building,	F INJURY - atc. (Specif)	- At home, farm	, street, fact	ory, offic	ce	28t. L	City or Town, State)	and Nomber of		rvarrous,
OR ATTENDI OR ATTENDI DIRECTOR: A nours after di	ETED	4 Homicide	Could not be detarmined	building,	atc. (Specif)	y) 				,	City or Town, State)			reginos,
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BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

	FOR STATE REGISTRAR	STATE OF MAR			MENT OF H		MENTAL HYGI			
- 3	1. DECEDENT'S NAME (First, Middle, Last)		_				2. DATE OF DEAT			3. TIME OF DEATH
1.0	Ernestine in	1	Geis	er			MONTH	DAY	YEAR	11 55 0 4
	4. SOCIAL SECURITY NUMBER 5	5. SEX 6. A	GE (In yrs. last	birthday) III	UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH	Cb	I a guntu	IPLACE (State or Foreign
	215-38-5789	1 DM 2 DF	56		NTHS DAYS	HOURS MIN,	(Month, Day, Yes	r)	Countr	y)
			06				Marchill	1939		nington,DC
DIRECTOR	9a. FACILITY NAME (If not institution, give	1 11 1- 1	al	9	Glen	BUCNI			UNITY OF D	Arundel
S	10a. STATE 10b. COUNT	TY		10c, CITY, T	OWN OR LOCAT	TION				10d. INSIDE CITY
		Arundel		Sever						LIMITS?
FUNERAL	7959 Telegraph Ro	oad Lot 123				21144			TIZEN OF W	VHAT COUNTRY?
5	11. MARITAL STATUS	12. WAS DECEDENT EVE			13. WAS DEC	ENDENT OF HISPAN	IIC ORIGIN? (Specify	Yea or No-	14. RACE	American Indian,
	1 Never Married 2 Married	FORCES? 1 Y		0		ecify Cuban, Mexica 2 X NO Specifi)	Speci	white, etc.
ВУ	3 Widowed 4 Divorced				100 100				100	ite
COMPLETED	15. DECEDENT'S ED	UCATION	16a. DEC	EDENT'S US	UAL OCCUPATIO	ON	16b. KIND OF	BUSINESS/IN		
E	(Specify only highest gred Elementary/Secondary (0-12)	College (1-4 or 5+)	(Givi	e kind of worl Do NOT use re	done during mo tired.)	st of working				
립	Grade 12		Hou	usewif	6		Own I	Toma		
8	17. FATHER'S NAME (First, Middle, Last)					46 MOTHER'S MA	ME (First, Middle, Ma			
	Ernest Meadows					1		iden Sumame)		
BE						Maude 1				
2	19a. INFORMANT'S NAME (Type/Print)					nd Number or Rural F				
-	George Geiser		79	959 Te	legrap	h Road, S	Severn, N	Maryla	nd 21	1144
	20a. METHOD OF DISPOSITION	=573.04000435+1	20b. PLACE AN	ND DATE OF I	ISPOSITION (Na	me of		LOCATION -		
	1 Donation 6 Other (Specify)	noval from State	Metro	Crema	atory,	Inc	11/29 0	atones	71110	, Maryland
	21. SIGNATURE OF FUNERAL BERVICE L			OL CITA		D ADDRESS OF FAI	CILITY	acons	TITE	/ Pary Land
- 13	01/11/	()///				dson Fune		P.A		
	Klow It Xen	A wille			313 Ta	albott Av	ve. Laure	al. Ma	rvlan	od 20707
	23. PART I. Enter the diseases, or	complications that cau	sed the dea	th. Do not	enter the mo	de of dying, auci	h se cerdiec or n	apiratory a	rreat.	Approximate
	snock, or neary failure.	List only one cause or	n each line.							
										Interval Between
	IMMEDIATE CAUSE (Final disease or condition		1	/	,	(Onset and Death
	disease or condition resulting in death)	a. myo	consli	1	in for	chon				
	disease or condition	a. DUE TO OR A	AS A CONSEOU	JENCE OF):	in br	chon				Onset and Death
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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed writinn 24 hours after death. Page 6 may be retained by the hospital or attending physician.

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IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	FOR 1 - STATE		STATE OF I	MARYLAN	ND / DEP/					MENT		E	95	38406	
	REGISTRAR 1. DECEDENT'S NAME (First,	Middle Leet)			CERTI	FICAI	E OF	DEA	IH	I a par	REG. NO			3. TIME OF OEATH	
10	GARY		ELTON			,				MON	TH D	AY 10	YEAR		
	4. SOCIAL SECURITY NUME		5. SEX	6. AGE (In)	yrs, lest birthde		HALI R 1 YEAR		R 24 HRS.	NO.	E OF BIRTH	19	9.5 A. BIRTI	HPLACE (State or Foreign	
17	220 02 67	20	17 M 2 □ F	33	YRS	MONTHS	DAYS	HOURS	MIN.	40	762		N.C	hari	
	220-82-67 9a. FACILITY NAME (If not in		treet and number)			9b. CIT	Y, TOWN	OR LOCAT	ION OF D	1		UNTY OF D			
H	PRINCE GE	ORGES	MEDIC	AI. CE	מידיותי	CHI	CHEVERLY								
DIRECTOR	RESIDENCE OF DEC	CEDENT		AD CI								LPK	LIVE	E GEORGES	
	10a. STATE MD	10b. COUNTY			10000	ilmer								10d. INSIDE CITY LIMITS?	
	10e. STREET AND NUMBER	- •	· · · · · · · · · · · · · · · · · · ·		1.0			. ZIP COE	\r			10- 01	PIREN OF	1 YES 2 □ NO WHAT COUNTRY?	
Y Y	2303 Rom	nev C	ourt					2078				_	J.S.		
FUNERAL	11. MARITAL STATUS	ne _j c	12. WAS DECEDEN	IT EVER IN U	J.S. ARMED	13				NIC ORIG	iiN? (Specify Yes	or No-	I 14. BAC	E — American Indian,	
1	1 Never Married 2		FORCES?	YES	2 XNO	"	If yes, sp		an, Maxic	an, Puert	Rican, etc.)		Blac	ik, White, etc.	
В	3 Widowed 4 Divo	orced		2000 1100 - 2000		_		70		.,.			Bla		
LED	15. DEC (Specify only	EDENT'S EDU	CATION completed)	16	6a. DECEDEN (Give kind	of work done	during me	ON ost of work	ing	1	66. KIND OF BU	SINESS/IN	DUSTRY		
LET	Elementary/Secondary (0	3-12)	College (1-4 or 5		Tabor	use retired.)			-	rivat.	0			
COMPL	1.0	liddle Leeth			Labor	ET		T 40 1400			, Middle, Maiden				
	Paul Hall	riddie, Listij						1			earn	Surname)			
2	19a. INFORMANT'S NAME (Type/Print)			19b. MAIL	NG ADDRES	SS (Street				mber, City or Tow	n. State. Z	(ip Code)		
2	Paul Hall										er Par			785	
1	20a. METHOD OF DISPOSIT				LACE AND OA								- City or T		
	1 Donation 5 Other		oval from Stala	Ha	rmony					7 1	/95 La				
	21. SIGNATURE OF FUNERA)									dwards	
	> panu	ce E	devar	de	/	3	3910	Si	lvei	r Hi	lll Rd	.Su	itla	ind, Md.	
CERTIFICATION	IMMEDIATE CAUSE (Fit disease or condition resulting in death) Sequentially list condit if any, leading to imme cause. Enter UNDERLY CAUSE (Disease or injuthat initiated eventa resulting in death) LAS	nel	c. DUE TO	OR AS A CO	ONSEQUENCE	E OF):					inds			Interval Between Onset and Death	
PHYSICIAN: MEDICAL	PART II. Other algorification of the part			AUSE OF	DEATH	YES 🗆	NO	UN	given in		PERFO		Y 24	b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO	
Š	25. WAS CASE REFERRED T EXAMINER?	TO MEDICAL	HOSPITAL: 1	26	S. PLACE OF E	OTHE									
2	27, MANNER OF DEATH		1 Inpatient 2		lent 3 DO	A 4 N	ursing Hor		Rasidenca	-	her (Specify)			1	
		Pending	26a. DATE 6	F INJURY	266.	TIME OF		JURY AT	VNO	28d. D	ESCRIBE HOW	INJURY O	OCURED	hat	
B	2 Accident 3 Suicide	Investigation	26a, PLACE	OF INJURY -	- At home, far	m. street. Is	_		XNO	28f L	DCATION (Street	and Numb	or or Burni	Boute Number	
Homicide determined building, etc. (Specify)										7°	ry or Town, State	M	NEV	Court	
29e. CERTIFIER								and etc.		1 /	אריייייי	UNI V	401		
ME	S court													(a) and menner as stated.	
	291 AND ATURE AND TITLE			.11	^				CENSE NU					D (Month, Day, Year)	
BE	1000	1	orke	χM	()				C.M.					29,1995	
0	36 A A A A A O O O ESS O	OF PERSON WH	O CHE	JSE OF SEAT	н (ITEM 27) (11 Ре		tre				ore.			d 21201	
	31. DATE FILED (Month, Day, DEC	4 199	5 July	ANG SIGNAT		4		•						- ~	

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IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020

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IVISIONO	

FOR 1 - STATE

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAR		CERTII	-ICAI E	OF	DEATH	REG. NO).		
	1. DECEDENT'S NAME (First, Middle, Lust) Jayne	Frances	Howe	11				995	YEAR	3:00 PM M
	4. SOCIAL SECURITY NUMBER 213 34 0505	5. SEX 1 M 2 F	6. AGE (In yrs. lest birthday 61 YRS.	IF UNDER MONTHS	1 YEAR DAYS	IF UNDER 24 HRS. HOURS MIN,	7. DATE OF BIRTH (Morth, Day, Year) July 18,	1934	Country	PLACE (State or Foreign y) yland
i	9a. FACILITY NAME (If not institution, give a	treet and number)		9b. CITY,	TOWN O	R LOCATION OF DE	ATH	9c. COU	INTY OF D	EATH
DIRECTOR	Crofton Convales	ent Cente	er	Cro	ftor	n		Anne	e Aru	ndel
Ä	10e. STATE 10b. COUNTY	r	10c. C	TY, TOWN O	R LOCAT	ION				10d. INSIDE CITY LIMITS?
	Maryland Princ	e George'	S	Upper	-	1boro		140- 017	PIZEN OF V	1 YES 2 TNO
FUNERAL	13909 King Grego	ry Way			101	20772	2			States
B⊀	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced		EVER IN U.S. ARMED YES 2 NO IR OR DATES		yes, sp		NO NO	ea or No-		- American Indian, t, White, etc. hy: White
	15. DECEDENT'S EDU	CATION	16a. DECEDENT	S USUAL OC	CUPATIO	ON	16b, KIND OF B	USINESS/IN	DUSTRY	
COMPLETED	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4 or 5+)	He Do NOT	f work done d use retired.) aker	turing mo	st of working	Own	Home	2	
Ž	17. FATHER'S NAME (First, Middle, Last)		Homen			10 MOTUED'S NA	ME (First, Middle, Maide			
BE CC		O'Hara					eth Krous			
	19a. INFORMANT'S NAME (Type/Print)						Route Number, City or R			
2	William W. Howel	ll Jr.					ay Upper M			
	20a. METHOD OF DISPOSITION 1 Department of Comment of	oval from State	20b. PLACE AND DAT cemetery or Dulaney	of Disposi Valle	y Me	emorial (Gardens I	imoni		aryland
	21. SIGNATURE OF FUNERAL SERVICE LIC	CENSEE		22.1	NAME AN	D ADDRESS OF FA	CILITY	1 11	-	
	Robert E.	Coun.	- tres				ans Funera lis Rd. Bo			
	23. PART I. Enter the diseases, or shock, or heert fellure.			not enter	the mo	de ot dying, suc	h as cardiac or rea	piratory s	rrest,	Approximats Interval Between
	IMMEDIATE CAUSE (Finsi disease or condition resulting in death)		2050100	tim		Arre	21			Onest and Death
	resulting in death)	DUE TO	OR AS A CONSEQUENCE	OF):	6		elew	0.1	2	C
CERTIFICATION	Sequentially list conditions, if any, leading to immediate	b DUE TO (OR AS A COMSEQUENCE	OF):		marie	(caeer	1000	7	37100
S	cause. Enter UNDERLYING CAUSE (Disease or Injury	C. DUE TO	OR AS A CONSEQUENCE	OE)						
E	that initiated events resulting in death) LAST	4		0. 7.						
	TARRETT AND THE RESIDENCE OF STREET	G					2 1			
EDICAL	PART II. Other significant condition	is contributing to	destri but not resultin	g in the un	derlyin	g cause given in		ORMED?	24b	AWAILABLE PRIOR TO COMPLETION OF CAUSE
EDIC						,	1 TYES	2 NO		OF DEATH?
Σ	DID TOBACCO USE CONT	PIRLITE TO CAL	ISE OF DEATH	/ES 🗆 N	VO F	UNCERTAL	NE			1 YES 2 NO
AN	25. WAS CASE REFERRED TO MEDICAL	T TO CA	26. PLACE OF DE			JONGERIA				
SICI	EXAMINER?	HOSPITAL:	ER/Outpatient 3 DOA	OTHER		se 8 Besidence	6 Other (Specify)			
PHYSICIAN:	27. MANNER OF DEATH	26s. DATE OF	INJURY 28b. T	IME OF	28c, INJ	JURY AT	26d. DESCRIBE HOV	/ INJURY O	CCURED	
ВУ Р	1 Netural 5 Pending 2 Accident Investigation	(Month, Da	ly, Year)	NJURY M		YES 2 NO				
ED B	3 Suicide S Could not be	28e, PLACE Of building,	INJURY — At home, farm etc. (Specify)	, street, fact	ory, offic	a	281. LOCATION (Stree City or Town, Ste		er or Rural I	Route Number,
H										
COMPLET	(Crieck Grity		my knowledge, deeth occ emination and/or investiga							s) and menner as steted.
BE CC	296. SIGNATURE AND THE OF CERTIFIE	R ()	01	0	^	29c, LICENSE NU	MBER	29d. DA	TE SIGNEC) (Month, Day, Year)
TO B	30, NAME AND ADDRESS OF PERSON WI	HO COMBI STED STATE	U Mo	20	21	W 1	022029	1	11-	6-95
	Paul Rhodes M.I	. 1667 (Crofton Cen	tre S	uite	e 1 Crof	ton Md. 21	114		
	31. DATE FILED (Month, Day, Year) DFC 4 199	32. PAGISTRA	S SIGNATURE O	6						

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Amended #7, 12/4/95, MRT, Montgomery County
FOR
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
REGISTRAR
CERTIFICATE OF DEATH
REG. NO. 1 -

	1123077047		OLIII.	TOME	. 01	DEAI	-	NEG. N	<i>J</i> .		
	1. DECEDENT'S NAME (First, Middle, Linst) Hazel M'Liss Ha:	rris							DAY	YEAR 3. TIME OF DEAT	
	4. SOCIAL SECURITY NUMBER 5. SEX				1				995 7:15	Ам	
	The state of the s	MONTHE DAYS MOURS MIN (Month, Day, Year)							1910	BIRTHPLACE (State or Fo Country)	reign
	9a. FACILITY NAME (If not institution, give street and numb	OT THO.	1 2 2 2				Dec. 19,				
œ			T			R LOCATIO	ON OF DEA	тн		ince Georges	- 4
<u>ē</u>	Greater Laurel Region	al Hosp:	ltal	L.	aure	5 T			Pr.	ince Georges	
EC	10a. STATE 10b. COUNTY		10c. C	ITY, TOWN O	R LOCAT	ION				10d. INSIDE CITY	
DIRECTOR	Maryland Montgome	ry	S	ilver	Spi	ring				1 YES 2	NO
	10e. STREET AND NUMBER				101	. ZIP CODE			10g. CI1	TIZEN OF WHAT COUNTRY?	
FUNERAL	726 Dennis Avenue					20	901			USA	
5	FORCES	CEDENT EVER IN						C ORIGIN? (Specify) , Puarto Rican, atc.)	ea or No-	14. RACE — American India Black, White, etc.	ю,
ВУ	1 Never Married 2 Married IF YES, 3 Widowed 4 Divorced				2 X NO		, Puerto Hican, atc.)		Specify:		
	15. DECEDENT'S EDUCATION		1				Torrison		White		
COMPLETED	(Specify only highest grade completed)	(Give kind o	'S USUAL OC if work done o use retired.)	CUPATIO	on ost of working	g	16b. KIND OF B	USINESS/IN	IDUSTRY	4.1	
1	Elamentary/Secondary (0-12) College (1-	Clerk					Groce	ry Si	tore	-	
M	17. FATHER'S NAME (First, Middle, Last)	OLCII	_ : :		18 MOTH	IFR'S NAM	IE (First, Middle, Maide		0010		
	Joseph Ernest Leizear						e Peirce	iii Guiriairie)			
BE	19a. INFORMANT'S NAME (Type/Print)	19b. MAILH	NG ADDRESS	(Street a			oute Number, City or To	wri. State. Z	(in Code)		
2	Donald Harris							heaton, 1		0902	
	20a. METHOD OF DISPOSITION		PLACE AND DAT			ime of		DATE 20c. I	OCATION -	- City or Town, Stata	
	1 [X] Burlei 2 Cremetion 3 Removal from St. 4 Donation 5 Other (Specify)	ceme Un	ion Cer	netery	7		12/	7/95 Bu	rtons	ville, MD	
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE					ND ADDRES				1 II T	
	* Steine 1 Stand	/								l Home, Inc. 1.Spr.MD 209	0.1
	23. PART i. Enter the disesses, or complication	na thet caused	the death. Do					~			
	shock, or heart failure. List only or	ne cause on ea	ch line.						p. a.tory o	Interval B	etween
	IMMEDIATE CAUSE (Final disease or condition D	CHIMAT	mia -	FM	In	in	aAm	V& Hyp	OYEY	2016 Oneat and	Death
	reaulting in death) a. 1 / 0	UE TO (OR AS A	CONSEQUENCE	OFI:	7 1 1	0770	-	Y - //)!	1		
-	01	1 age	- D	sud	On	10V2	w	me	non		
<u> </u>	Sequentially list conditions, if any, leading to immediate	UE TO (OR AS A	CONSEQUENCE	OF):		. 0	1	Ovanu	0).		
CERTIFICATION	cause. Enter UNDERLYING CAUSE (Disease or injury	yean v	Sulve	OTEC		Cell	eu	Vasto	(9)1	in	
E	that initiated eventa	UE TO (OR AS A	CONSEQUENCE	OF):							
EH	resulting in death) LAST									ļ	
	PART II, Other algorificant conditions contribut	ing to death bu	it not resultin	g In the un	deriyin	g cause g	iven(in F	art I. 24a, WAS /	N AUTOPSY	24b. WERE AUTOPSY FI	NOINGS
EDICAL	Rhonmaton	401m	nHis	01	/ U	an	(e)	PERF	ORMED?	AMILABLE PRIOR COMPLETION OF C	TO
	1								2 DAVO	OF DEATH?	40
2	DID TOBACCO USE CONTRIBUTE TO	O CAUSE OF	DEATH	YES 🗆 N	NO [UNC	ERTAIN			10.123 20.1	
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL		8. PLACE OF D								
Sic	EXAMINER? 1 YES 2 NO 1 Inpatia	NL: nt 2 ER/Outpe	itlent 3 🗆 DOA	OTHER		1e 5 □ Ra	aldenca 8	3 Other (Specify)			
<u>₹</u>		ATE OF INJURY		IME OF NJURY	28c. fNJ	URY AT		28d, DESCRIBE HOY	/ INJURY O	CCURED	
	1 Natural 5 Pending	Criti, Day, rear)		M		YES 2	NO				
	2 Applicant Investigation		-		ony offic			201 LOCATION (Com	d a med Africants	er or Rural Route Number.	
ВУ	2 Accident Investigation 3 Suicide 8 Could not be	ACE OF INJURY	— At home, fam	1, Street, facto	o. y. o	in .				er or nural noble mumber,	
ED BY	3 Suictile 28a. Pi	ACE OF INJURY illding, atc. (Speci	— At home, fam fy)	i, atreet, facti	ory, orne	a		City or Town, Sta		or or nursi nouse municios,	
ED BY	3 Suicide 8 Could not be determined 28a. Piblio determined 29a. CERTIFIER 1 CERTIFUING PHYSICIAN: To the	ıllding, atc. (Speci	fy)				and due 1	City or Town, Sta	10)		
ED BY	3 Sulcide 8 Could not be detarmined	iliding, atc. (Speci best of my knowle	edge, death occi	irred at the fl	me, deta	and placs,		City or Town, Sta	enner aa st	ated.	teted,
COMPLETED BY	3 Suicide 8 Could not be detarmined 29s. CERTIFIER (Check only	iliding, atc. (Speci best of my knowle	edge, death occi	irred at the fl	me, deta	and placs,		City or Town, State to the cause(a) and milme, data and place,	enner as st	ated. the cause(a) and menner as a	tated.
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95 38409 FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH Mae 25, Ada Hinebaugh 1995 5:15 PM November 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. lest birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH S. BIRTHPLACE (State or Foreign Aug. 23, 1909 HOURS DAYS 515-36-4710 1 M 2 F California 86 9a. FACILITY NAME (If not institution, give street and number, 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH 607 Sonata Way DIRECTOR Silver Spring Montgomery RESIDENCE OF DECEDENT 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Silver Spring Montgomery TES 2 NO FUNERAL 10a STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 20901 607 Sonata Way United States 11. MARITAL STATUS 12. WAS OCCEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— It yes, specify Cuben, Maxican, Puerto Rican, etc.) 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Married 1 YES 2 NO Specify 3 Wildowed 4 Divorced BY White COMPLETED 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only high Elementary/Secondary (0-12) College (1-4 or 5+) Public Schools/Special Education +6 Teacher 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Lillian Knizley William E. Hadduck BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADORESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Ruth H. Begin 607 Sonata Way, Silver Spring, MD 20901 20a. METHOD OF DISPOSITION OATE 20c. LOCATION - City or Town, State 20b. PLACE AND DATE OF DISPOSITION (Name of 1 Donation 5 Other (Specify) Nov. 30, 1995 Milford, KS 22. NAME AND ADDRESS OF FACILITY 21. SIGNATURE OF MINISTAL SERVICE LICENSEE Hines-Rinaldi Funeral Home 11800 New Hampshire Ave Silver Spring MD PARO I. Enter the diseases, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Liet only one ceuee on each line. interval Between Onset and Death IMMEDIATE CAUSE (Finel disease or condition neumonia /wek reaulting in daeth) OUE TO (OR AS A CONSEQUENCE OF): CERTIFICATION Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING DUE TO (OR AS A CONSEQUENCE OF): CAUSE (Disease or injury OUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in deeth) LAST PART II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS MEDICAL AMILABLE PRIOR TO COMPLETION OF CAUSE Heart 1 YES 2 NO OF DEATH? 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES IN NO W UNCERTAIN I PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) 1 YES 2 NO 1 | Inpetient 2 | ER/Outpetient 3 | DOA 27. MANNER OF DEATH 28a. OATE OF INJURY 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED Natural 1 YES 2 NO BY Accident 28s. PLACE OF INJURY — At home, larm, street, factory, offica building, atc. (Specify) 28t. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 8 Could not be COMPLETED 4 Homicide 29s. CERTIFIER
(Check only one)

CERTIFING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE Mbuember 26, 1995 D37975

32. REGISTRAR'S SIGNATURE

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

J. Indrisano, M.D.

31. DATE FILED (Month, Day, Year)

9801 bearsin the Silver Spring MD 20902

y the total arrive

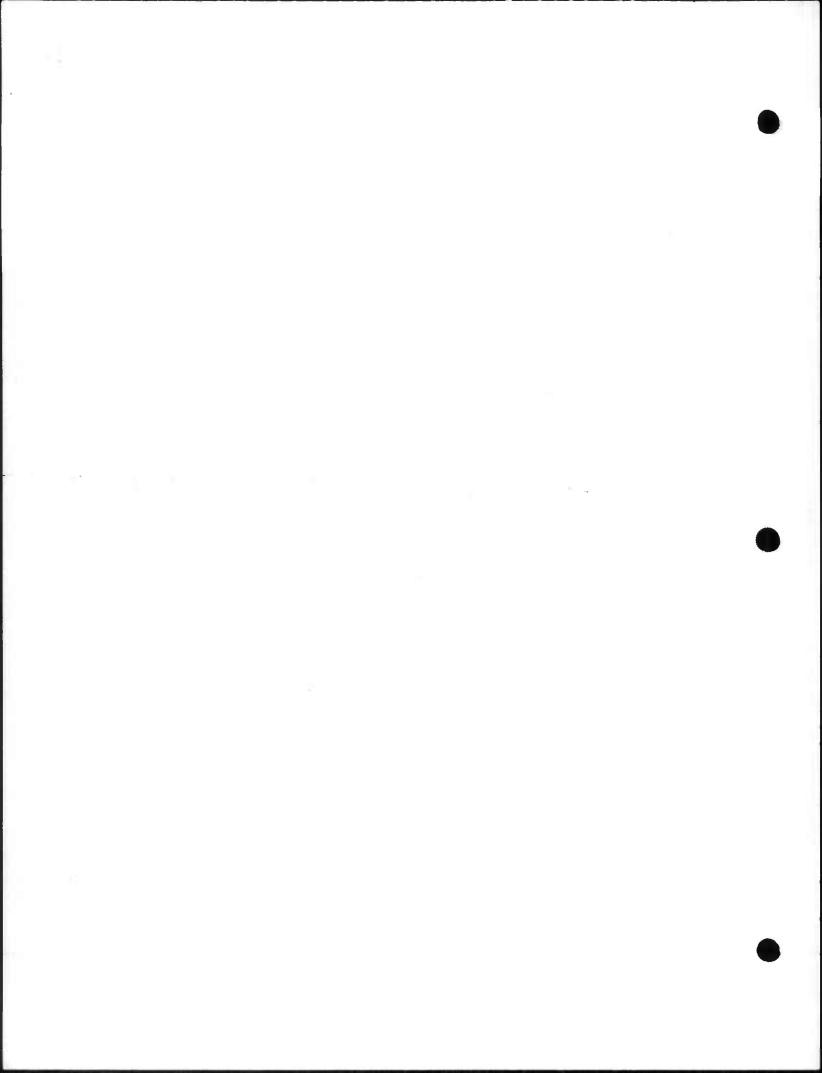
BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: if item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPA	RTMENT (OF H	EALTH AND DEATH	MENT	AL HYGIEI				
	1. DECEDENT'S NAME (First, Middle, Last)						2. DA	TE OF DEATH			3. TIME OF DEAT	ГН
	Не	elen Lanora	Heasle	У			Dec		2, 19	95	4:28	Рм
	4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE	(In yrs. last birthday			IF UNDER 24 HRS.	7. DAT	E OF BIRTH	,	S. BIRT	HPLACE (State or Fo	oreign
- 1	218-24-3640		88 yrs.	MONTHS 6	DAYS	HOURS MIN.		il 6.	1907	Per	nsylvan:	ia
	9a. FACILITY NAME (If not institution, give	street and number)		9b. CITY, T	OWN C	R LOCATION OF E				NTY OF		
FUNERAL DIRECTOR	Kensington Garden		ome		Ke	nsingto	n			Мот	ntgomery	
뿐	10e. STATE 10b. COUNT		10c. C	TTY, TOWN OR							10d. INSIDE CITY	,
ה ה	Maryland Mont	tgomery		Ro	-	ille			100 CIT	IZEN OE	1 YES 2 □ WHAT COUNTRY?	NO
ERA	119 Rollins Avenu	ue					852		log. Cit	USA		
	11. MARITAL STATUS	12. WAS DECEDENT EVER I FORCES? 1 YES	N U.S. ARMED			ENDENT OF HISPA			e or No-	14. RAC	E American Indi	in,
BY	1 Never Merried 2 Merried 3 Widowed 4 Divorced	IF YES, GIVE WAR OR D		10	YES	city Cuben, Mexic 2 NO Speci	illy:	o recan, etc.)			White	
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	(Specify only highest grad	le completed)	16a. DECEDENT (Give kind o	of work done dur use retired.)	ing mo	on st of working	- 1	66. KIND OF BU	/SINESS/INI	DUSTRY		
로 [Elementary/Secondary (0-12)	College (1-4 or 5+)	77 3	cher				Educa	tion			
COMPLETED	17. FATHER'S NAME (First, Middle, Last)	_				18. MOTHER'S N	AME (First					
	Dalton Curtis Wh:	ite				Criss			nche			
BE	19a. INFORMANT'S NAME (Type/Print)		19b. MAILIN	NG ADORESS (S	Street a	nd Number or Rural	Route Nu	mber, City or Tox	vn, State, Zia	Code)		
2	Lexie McMahon					n Avenue				,	20902	
ĺ	20a. METHOD OF DISPOSITION 1 St Burlel 2 Cremetion 3 Ren		o. PLACE AND DAT		ON (Na	me of	0/	ATE 20c. L	OCATION -	City or To	own, State	
	4 Donation 5 Other (Specify)	F	ranklin	Cemete			12/5	/95 Fra	nkli	n, P	ennsylva	nia
	21. SIGNATURE OF FUNERAL SERVICE LI	CENSEE - PL	1	Fra	nci	S J. Co	11in				Inc. MD 2090	1
	23. PART I. Enter the disease, or shock, or heart fellure. IMMEDIATE CAUSE (Finel disease or condition resulting in death)	a. METAST	each line.	LIVI	R	Dish		TOTAL TOTAL	whatory an	,	Approxim Interval B Onset and	etween
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury	" METAS	TATR A CONSEQUENCE	W (N DIZK		- Li				
E L	thet initiated events resulting in death) LAST	d. CANC	A CONSEQUENCE		UN.							
¥ I	PART II. Other algnificent condition	na contributing to deeth b	out not resulting	g in the unde	erlying	ceuse given in	Part I.	24a. WAS AI PERFO	N AUTOPSY	241	. WERE AUTOPSY FO	TO
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	2 Accident Investigation 3 Suicide 6 Could not be	26s. PLACE OF INJURY building, etc. (Spe	/ — At home, ferm				281. LC	OCATION (Street ty or Town, State	and Number	or Rural	Route Number,	
	4 Homicide determined											
COMPLEIED		SICIAN: To the best of my know ER: On the basis of examination									s) and manner ea s	lated.
	29b. SIGNATURE AND TITLE OF CORTIFIE					29c. LICENSE NU					(Month, Day, Year)	
	Mong - W.	and m	·D			D. 1		56	> \$)65	2 95	
2	30. NAME AND ADDRESS OF PERSON WA		5530		CIN	SIN AI			LIV	UST	m / 2015	15
	31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGN		W120	VIV	3/1/1/1/	VL , 1	CNEVA	Car	1125	120 00	2, 0.
	DEC 05 1995	Julia Davelson	-Rardall						1			



YEAR 1995

3. TIME OF OEATH

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Approximats Interval Between **Qoset and Death**

REG. NO. 2. DATE OF OEATH

December 4

FOR STATE REGISTRAR

4. SOCIAL SECURITY NUMBER

1. DECEDENT'S NAME (First, Middle, Last)

Dorothy

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7. DATE OF BIRTH (Month, Day, Year) March 27, 8. BIRTHPLACE (State or Foreign DAYS HOURS MIN. 213-48-2644 1 M 2 K F Pennsylvania 1917 78 permit, Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF OEATH DIRECTOR 2804 Federal Lane Bowie Prince George's RESIDENCE OF DECEDENT 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Texas Hidalgo Edinbura 1 X YES 2 NO FUNERAL 10e. STREET AND NUMBER 101. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 1607 West Schunior Street filled in by the funeral director, page 5 should be detached for use as the burial-transit ion, or removal. 78539 United States hours after death. Page 6 may be retained by the hospital or attending physician. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-14. RACE — American Indian, Black, White, atc. # yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 VES 2 NO Specify: 1 Never Married 2 Married BY 3 Wildowed 4 Divorced Specify: White 16a. DECEDENT'S USUAL OCCUPATION ETED. 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5 +) COMPL 12 Portrait Artist/Homemaker | Self-employed / Own Home 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Otto Theodore Post notified at Ethel Hamilton 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Bradford Haughey 4424 Ridge Street, Chevy Chase, MD 20815 Pe 20e. METHOD OF DISPOSITION 20c. LOCATION — City or Town, State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE must Buriel 2 Cremation 3 Removal from State

Donetion 5 Other (Specify) National Memorial Park Falls Church, Virginia examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Deen Rapp Funeral Services, P. A. 933 Gist Avenue, Silver Spring, MD 20910 medicai 23. PART I. Enter the diseases, or complications that caused the dasth. Do not enter the mode of dying, such as cardiec or respiratory errest, shock, Dr haert feliure. List only one ceuse on each line. IMMEDIATE CAUSE (Final Concer 5 - 1/ col the cremation, disease or condition ysician and completely prior to burial, crematic event, 1 resulting in death) DUE TO (OR AS A DONSEQUENCE OF): executed traumatic CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate the attending physician Mental Hygiene prior to 8 cause. Entar UNDERLYING CAUSE (Disease or Injury certificate other DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 0 PART ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS MEDICAL has been signed by Dept. of Health and **AMILABLE PRIOR TO** shows any COMPLETION OF CAUSE 1 YES 2 X NO OF DEATH? 1 YES 2 X NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) Hem the State EXAMINER? certificate HOSPITAL: OTHER: OR ATTENDING PHYSICIAN: 1 | Inpatient 2 | ER/Outpatient 3 | DOA ng Home 5 XResidence 8 Other (Specify) 10 27. MANNER OF DEATH DIRECTOR: After this cer hours after death with the item 28 is marked, c 28a. DATE OF INJURY 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 X Natural 5 Pending investigation M 1 YES 2 NO BY 2 Accident 26a. PLACE OF INJURY — At home, farm, street, factory, offica building, etc. (Specify) 3 Suicide 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined COMPLETED 4 Homicide 29a. CERTIFIER (Check only CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(e) and manner as stated. FUNERAL I = TO THE MOSPITA
TO THE FUNERA
De filed within 72
IMPORTANT: II 2 MEDICAL EXAMINER: On the basis of exemination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and menner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE D3 4703 mer December 4, 0 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 3231 Superior Lane, #A6 DUNO Bowie, MD 20715 32. BEGISTRAR'S SIGNATURE 31. DATE FILED (Month, Day, Year) DEC 05 1995

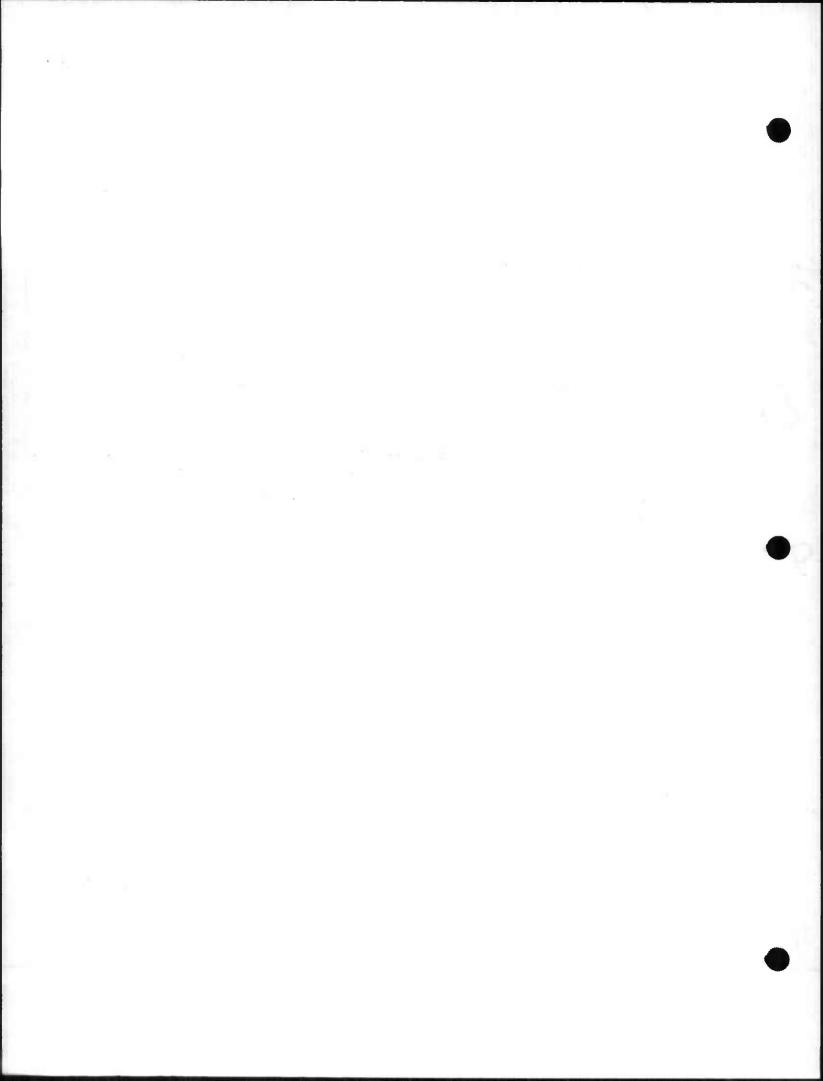
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

IF UNDER 1 YEAR

Haughey

6. AGE (In yrs. last birthday

DHMH-18 Rev 1/89



D THE HOSPITAL OR ATTORNEY OF THE FUNERAL DIRECTION OF filed within 72 hours at IMPORTANT: If Item 2
D THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hosp of THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached. Fe filed within 72 hours after death with the State Dept. of Health and Mental Hyglene prior to burial, cremation, or removal. IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.
D THE HOSPITAL OR ATTEN O THE FUNERAL DIRECTOR: DE filed within 72 hours after IMPORTANT: If Item 28 1
TO THE HOSPITAL OR THE FUNERAL DIR. DE fied within 72 hour IMPORTANT: If Item
D THE HOSPITA O THE FUNERA DE filed within 7
O THE P THE F De filed v

1 - STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REGISTRAR CERTIFICATE OF DEATH REG. NO.

	REGISTRAR				CERTII	-IUA	IE OF	DEATH		REG. NO.			
	1. DECEDENT'S NAME (First,									TE OF DEATH	Y	YEAR	3. TIME OF OEATH
	Amalia K		HARDY						De	cember	1	1993	11:45 Pm
	4. SOCIAL SECURITY NUMB		5. SEX	6. AGE (in	yrs. lest birthday	IF UN	DER 1 YEAR	IF UNDER 24 HRS. HOURS MIN,		TE OF BIRTH onth, Day, Year)		8. BIRTH Countr	PLACE (State or Foreign
	517-12-4785		1 M 2 F	7	7 YRS.	WORT	- Carro	MOUNS MIN.		uary 18,	1918		tana
~	9e. FACILITY NAME (If not in:					9b. C	ITY, TOWN	OR LOCATION OF	DEATH		9c. COL	INTY OF D	EATH
DIRECTOR	Doctors Co	mmunia	ty Hospit	tal			Lanh	.am			Pr	ice G	Georges
<u> </u>	RESIDENCE OF DEC	10b. COUNTY	,		100 0	TV TOW	N OR LOCA	TION					
	Maryland	Princ	e George	10	1 2 2 2		dale	IIION					10d. INSIDE CITY LIMITS?
	10s. STREET AND NUMBER	111110	e dedige	. 3	KI	VEI		H. ZIP CODE			40. 0.0		1 X YES 2 NO
Y	6609 Oaklan	d Awar	1110				1"	20737					VHAT COUNTRY?
FUNERAL	11. MARITAL STATUS	d MVCI	12. WAS DECEDEN	T EVED IN 1	I S ADMED		12 480 050	CENDENT OF HISPA	AND 001	000000000000000000000000000000000000000		S.A.	
							If yee, sp	pecify Cuben, Mexic	en, Puer	to Rican, etc.)	or no —		— American Indian, t, White, etc.
B	3 🗵 Widowed 4 🗌 Divor	MAH OH DATI	E8		1 L YES	S 2 X NO Spec	lly:			Speci	White		
	15. DECI	EDENT'S EDUC	CATION	1	6a. DECEDENT	S USUAL	OCCUPATI	ON	1	16b. KIND OF BUS	INESS/IN	DUSTRY	
COMPLETED	Elementary/Secondary (0-	T	College (1-4 or 5	+)	life. Do NOT	use retire	ne dunng me d.)	ost of working					
<u> </u>			5+		Guidano	ce C	ounse	elor	I	Riverdal	Le Ba	aptis	t School
ਤੂ	17. FATHER'S NAME (First, Mi	1111						16. MOTHER'S N	AME (Firs	I, Middle, Meiden	Surname)		
	Wilhelm		ing					Justi		Geh		0	
<u> </u>	190. INFORMANT'S NAME (Ty					end Number or Rura							
	Catherine H				6514	Oak.	Land .	Avenue,	Rive	erdale,	Mary	land	20737
	20e. METHOD OF DISPOSITION 1 1 Burlet 2 Cremation	n 3 🗆 Remo	ovel from State	20b. P	LACE AND DATE ery, crematory or	OF DISF	OSITION (N	ame of	D.	ATE 20c. LOC	CATION —	City or To	wn, State
	4 Donation 6 Other 21. SIGNATURE OF FUNERAL		ENGEE	For	t Line			tery 12		95 Bren	two	od, M	aryland
and the party of the party of the party										е. Р Δ			
	Clearles F. Bell, Francis Gasch's Sons Funeral Home, I 4739 Baltimore Ave., Hyattsville, MD												
EHILICATION	IMMEDIATE CAUSE (Findsease or condition resulting in death) Sequentially list condition if any, leading to immediates. Enter UNDERLYII CAUSE (Disease or injurithat initieted events resulting in death) LAST	ons, Hate		(UH AS A C	ONSEQUENCE (OF):	MON	NARY	FiB	Rosis			Interval Batween Onset and Death
	PART II. Other algnificar	nt condition	e contributing to	death but	not resulting	in the	underlyin	a cause alven in	Part I	24a. WAS AN	ALITOPEV	246	WERE AUTOPSY FINDINGS
DICAL.										PERFOR	MED?	1	AVAILABLE PRIOR TO COMPLETION OF CAUSE
u I										1 TYES 2	X NO		OF DEATH?
2	DID TOBACCO US	SE CONTR	RIBUTE TO CA	USE OF	DEATH Y	FS [NO S	T UNCERTAL	N \square				1 YES 2 NO
Ä	25. WAS CASE REFERRED TO				PLACE OF DE								
HISICIAN	EXAMINER?		HOSPITAL:	ER/Outpeti	ent 3 🗆 DOA	OTH 4 🗆		ne 6 Residence	6 🗆 OI	her (Specify)			
E	27. MANNER OF DEATH		28e. DATE OF (Month, D	INJURY	28b. TI	ME OF	28c. IN.	JURY AT	1	ESCRIBE HOW IN	JURY OC	CURED	
		Pending Investigation	(MORRI, D	wy, rour/	- "	JURY M		YES 2 NO					
- 11	3 Suicide 8 0	Could not be	26e. PLACE O building,	F INJURY — etc. (Specify)	At home, ferm,	street, i	actory, offic	20	281. L	OCATION (Street erity or Town, State)	nd Numbe	or Rural R	oute Number,
COMPLEIED	4 Homicide d	letermined							~	ty or rown, siete,			
7	29e. CERTIFIER (Check only	FYING PHYSIC	CIAN: To the best of	my knowled	ige, death occur	red at th	e time, dete	end place, and du	e to the	cause(e) end man	ner ee sta	ted.	
5													end menner ee stated,
	29b. SIGNATURE AND TITLE	OF CERTIFIER						29c. LICENSE NU	MBER		29d, DAT	E SIGNEO	(Month, Day, Year)
20	ME	5 N	partice					D-1	78	74			3-9-
2	30. NAME AND ADDRESS OF			SE OF DEATH	38 6		Bi	ROWIN	روى	MA	2	072	2
	31. DATE FILED (Month, Day,)	-	32. прбутла	PIS SIGNATI					-	1 2			
	DEC :	8 1995	gala	OWNE		•							

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ITEMS: 23 PART I, 27, PER MEO FILM G-730 12/29/95 t.t

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 -CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH DAY YEAR NOV.27,1995 11:47 HAROLD WILLIAM HEINRICHS JR. AM 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH (Month, Day, Year 8. BIRTHPLACE (State or Foreign Country) IF UNDER 1 YEAR IF UNDER 24 HRS. DAYS HOURS MIN. 1. M 2 F 217 46 3632 50 20 Sept. 945 Akron, Ohio Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH ANNE ARUNDEL GENERAL HOSPITAL DIRECTOR Annapolis ANNE ARUNDEL 10b. COUNTY 10c, CITY, TOWN OR LOCATION 10d. INSIDE CITY t XXXES 2 NO Maryland Prince George's Bowie permit. FUNERAL 10e. STREET AND NUMBER 101. ZIP CODE tog. CITIZEN OF WHAT COUNTRY? 12809 Cherrywood Lane the burial-transit 20715 United States hours after death. Page 6 may be retained by the hospital or attending physician. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or Not4. RACE — American Indian, Black, White, atc. BALTIMORE, MARYLAND 21215-0020 If yes, specify Cuben, Maxican, Puerlo Ricen, etc.)

1 YES 2 NO Specify: 1 Never Married 2 Married BY 3 Widowed 4 Divorced 1965-1966 White SS ETED ts. DECEDENT'S EDUCATION tea. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY use (Specify only highest grade cor during most of working ě Elementary/Secondary (0-12) College (1-4 or 5+) COMPL page 5 should be detached 12 Home Improvement Self. once. 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Surname) Harold William Heinrichs, Sr. 7 Katherine Arendt notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Debra A. Heinrichs 12809 Cherrywood Lane Bowie Maryland 20715 9 20a, METHOD OF DISPOSITION
t 👺 Burlal 2 🗆 Cremation 3 🗆 Ramoval from Stata 20c. LOCATION - City or Town, Stata 20b. PLACE AND DATE OF DISPOSITION (Name of DATE must funeral director, Oak Church_Cemetery 12/2/95 Mt. 4 Donation 5 Other (Specify) Mitchellville Md. examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Robert Robert E. Evans Funeral Home, P.A. 16000 Annapolis Rd. Bowie Md. 20715 the the medical 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate interval Between filled in by ahock, or heart fallure. List only one cause on each line ö Onset and Death IMMEDIATE CAUSE (Final the cremation, disease or condition ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE completely recuiting in death) traumatic event, DUE TO (OR AS A CONSEQUENCE OF): burial, CERTIFICATION and Sequentially list conditiona, DUE TO (OR AS A CONSEQUENCE OF): prior to If any, leading to immediate cause. Enter UNDERLYING physician that the death certificate be other 1 CAUSE (Disease or Injury the attending physical difference of Mental Hygiene p DUE TO (OR AS A CONSEQUENCE OF): that initiated evente resulting in deeth) LAST 6 PART II. Other significent conditions contributing to deeth but not resulting in the underlying ceuse given in Part i. 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE MEDICAL signed by the shows any 1 YES 2 NO OF DEATH? DR ATTENDING PHYSICIAN: The law requires 1 XYES 2 NO peen 0 has be Dept. . DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: 26. PLACE OF DEATH (Check only one, 25. WAS CASE REFERRED TO MEDICAL Item certificate to the State 1 YES 2 NO HOSPITAL: OTHER: t 🗆 inpetient 2 🗙 ER/Outpetient 3 🗆 DOA 4 - Nursing Home 5 - Residence 6 - Other (Specify) 10 the 27. MANNER OF DEATH 26a. DATE OF INJURY (Month, Day, Year) 28h. TIME OF 28c. INJURY AT WORK? 28d, DESCRIBE HOW INJURY OCCURED this c marked, INJURY 1 XXNatural 5 Pending 66 1 YES 2 NO BY After investigation 2 Accident 26e. PLACE OF INJURY — At home, term, street, factory, office building, atc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City of Town State) 3 Sulcide 6 Could not be determined 49 DIRECTOR: J COMPLETED 4 Homicide 28 tem 29a. CERTIFIER

//Chack note

1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. FUNERAL (HOSPITAL = 2 💢 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and manner as stated. IMPORTANT: 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Yber) 표 BE odere Revy NOV.28,1995 any) OCME 223 9 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MIKIM HEUDORE 111 Penn Street, Baltimore, Maryland 21201 31. DATE FILED (Month, Day, Year) 32 REGISTRAR'S SIGNATURE

BOX 6876 DIVISION OF VITAL RECORDS, P.O.

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TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within a few death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG NO.

	REGISTRAR		<u> </u>	ERIT	ICALE	Ur	DEAL	П	R	EG. NO.			
	1. DECEDENT'S NAME (First, Middle, Last)								2. DATE OF	DEATH	AY .	YEAR	3. TIME OF DEATH
	WOOI	T	OWARD						Decem	ber	5, 1		6:15 A. M
	4. SOCIAL SECURITY NUMBER	1.0	6. AGE (In yrs. las		IF UNDER I	DAYS	IF UNDER	24 HRS.	7. DATE OF E (Month, Da			8. BIRTH Countr	IPLACE (State or Foreign
	218-12-1060	1 № M 2 🗆 F	81	YRS.		Contra	Houns	wire.	Mar. 1	1, 1	914		ryland
~	9a. FACILITY NAME (If not institution, give :						R LOCATIO				9c. COU	NTY OF D	EATH
ا ق	Home- 5820 Harry	Ma	ario	on St	atio	n, MD		Some	rset				
DIRECTOR	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNT	Y		10c. CIT	Y, TOWH OF	BLOCAT	ON						10d. INSIDE CITY
Maryland Somerset Marion Station													LIMITS?
	10e. STREET AND NUMBER	I BALL .	_	. ZIP CODE				10a, CIT	ZEN OF W	WHAT COUNTRY?			
ER	5820 Harry Burto					2183	8			U.S	A		
5	11. MARITAL STATUS	13. W	AS DEC	ENDENT O	F HISPAN	IC ORIGIN? (S	pecify Yea	or No—	14. RACE	- American Indian.			
106. STREET AND NUMBER 5820 Harry Burton Road 11. MARITAL STATUS 1 Never Married 2 Married 13 Widowed 4 Divorced 106. ZIP CODE 21838 107. ZIP CODE 11. WAS DECEMBENT OF HISPANIC ORIGINATION OF										n, etc.)		Black Speci	k, White, atc.
											White		
Ē	15. DECEDENT'S EDUCATION (Specify only highest grade completed) 16a. DECEDENT'S USUAL OCCUPATION (Specify only highest grade completed) 16b. KIND OF BUSINESS/INDUSTRY (Give kind of work done during most of working life. Do NOT use relief.) 16b. KIND OF BUSINESS/INDUSTRY 16b. KIND OF BUSINESS/INDUSTRY 16b. KIND OF BUSINESS/INDUSTRY 17b. DECEDENT'S USUAL OCCUPATION (Give kind of working life. Do NOT use relief.) 17b. DO NOT use relief.) 17b. TATHER'S NAME (First, Middle, Last) 17b. TATHER'S NAME (First, Middle, Maiden Surnsme)												
Elementary/Secondary (0-12) College (1-4 or 5+) Iffe. Do NOT use retired.)													
Unknown Unknown Truck Driver Trucking 17. FATHER'S NAME (First, Middle, Last)													
SO INCOMANT'S NAME (Teacher)													
임	Harold Leon Palmer Mailing Address (Street and Number of Rural Route Number, City or Yown, State, Zip Code) Harold Leon Palmer S818 Harry Burton Rd Marion Station, MD 21838										21838		
20s. METHOD OF DISPOSITION 20h PLACE AND DATE OF DISPOSITION (Name of													
	1 Burial 2 Cremation 3 Ram 4 Donation 5 Other (Specify)	oval from State	cemetery, cre			_	_		DATE	_			
	21. SEGMATURE OF PUNERAL SERVICE LICENSEE RONald Wade, Dir. 22. NAME AND ADDRESS OF FACILITY STATE ANATOMY BOARD											DAPD	
1	655 W Baltimore St - Baltimore MD 21201												
\neg	Robert H. Bras	dshaw. Jr.	coursed the de	eth Do s									
ł	23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ahock, or heart failure. List only one cause on each line. Approximate intervsi Between												
ł	iMMEDIATE CAUSE (Final disease or condition resulting in death) a. CARCINOMA LUNC And And And And And And And An												
ł	reaulting in death)	DUE TO (OR AS A CONSE			' / /			77	L			10 may
Z		h											i 'i
CERTIFICATION	Sequantially list conditions, if any, laading to immediate	DUE TO (0	OR AS A CONSEC	DUENCE OF):								
S	cause. Enter UNDERLYING CAUSE (Disease or Injury	с											
=	that initiated events resulting in death) LAST	DUE TO (OR AS A CONSEC	DUENCE OF	7):								
H	Tooding in death, Exs.	d											
	PART ii. Other significant condition	na contributing to d	laath but not r	aauiting i	n tha und	deriying	cause g	ivan in F	Part i. 24a		AUTOPSY	24b.	WERE AUTOPSY FINDINGS
EDICAL										PERFOR			AMAILABLE PRIOR TO COMPLETION OF CAUSE
						_	-		_ '`	YES 2	KI M		OF DEATH?
2	DID TOBACCO USE CONT	RIBUTE TO CAU	JSE OF DEA	TH YE	SIVIN	ЮГ	UNC	ERTAIN					1 YES 2 NO
₹ I	25. WAS CASE REFERRED TO MEDICAL EXAMINER?			E OF DEAT	$\overline{}$		0.10						
SIC	1 CYES 2 NO	HOSPITAL:	ER/Outpatient 3	□ DOA	OTHER:		5 (X)Ra	aldence (Other (Sp	ecify)			
PHYSICIAN:	27. MANNER OF DEATH	28a. DATE OF II (Month, Day		28b. TIMI	E OF 2	28c. INJ	URY AT		28d. DESCRIE	BE HOW II	NJURY OC	CURED	
BY	1 Natural 5 Pending 2 Accident Investigation	(М		ES 2	NO					
									281. LOCATIO	N (Street a	nd Number	or Rural R	loute Number,
	4 Homicide determined												
ETED	The state of the s												
PLETED	29a. CERTIFIER (Check only)	ICIAN: To the best of ri	ny knowledga, da	ath occurre	d at the tin	ne, data	and placa,	and dua t	to the cause(a)	and man	ner an stat	led.	
OMPLETED	00- 00001000) and manner as stated.
E COMPLETE	29a. CERTIFIER (Check only 1 CERTIFYING PHYS	R: On the basis of axa					eath occur		lme, data and		d due to th	ne cause(a)) and manner as stated.
BE COMPLETE	296. CERTIFIER (Check only one) 2 MEDICAL EXAMINE 296. SIGNATURE AND TITLE OF CERTIFIE	R: On the basis of axa	minetion and/or i	investigation	n, in my op		eath occur	ed at the t	lme, data and		d due to th	ne cause(a)	
E COMPLETE	296. CERTIFIER (Check only one) 2 MEDICAL EXAMINE 296. SIGNATURE AND TITLE OF CERTIFIE 30. NAME AND ADDRESS OF PERSON WITH	R On the basis of axa	Of DEATH (ITEE	nveatigation	Print)	inion, d	29c. LICE	NSE NUM	BER		d due to th	ne cause(a)	
BE COMPLETE	29a. CERTIFIER (Check only one) 2 ☐ MEDICAL EXAMINE 29b. SIGNATURE AND TITLE OF CERTIFIE 30. NAME AND ADDRESS OF PERSON WH M. D. Barhan, M.	R On the basis of axa	Of DEATH (ITEE	nveatigation	Print)	inion, d	29c. LICE	NSE NUM	BER		29d. DAT	ne cause(a)	
BE COMPLETE	296. CERTIFIER (Check only one) 2 CERTIFYING PHYS 2 MEDICAL EXAMINE 296. SIGNATURE AND TITLE OF CERTIFIE 30. NAME AND ADDRESS OF PERSON WH. M. D. Barhan, M. 31. DATE FILED (Month, Day, Year)	R On the basis of axa	Of DEATH (ITEL Crisfie	nveatigation	Print)	inion, d	29c. LICE	NSE NUM	BER	place, an	29d. DAT	ne cause(a)	

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funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should

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examiner must be notified at once.	IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	-
ie funeral director, page 5 should be detached.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and competely lilled in by the funeral director, page 5 should be detache be filed within 72 hours after death with the State Dept. of Health and Merital Hygiene prior to build, cremation, or removal.	
r death. Page 6 may be retained by the hosp	TO THE HOSPITAL DR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within Actions after death. Page 6 may be retained by the hosp	-

31. OATE FILEO (Month, Day, Year)
DEC05 1995

	FOR 1 - STATE REGISTRAR	STATE OF N	MARYLAND A	DEPAR ERTIF						YGIEN EG. NO.	E		
	1. DECEOENT'S NAME (First, Middle, Last)	DORIS	Α.		+	INT	MAN	1	2. DATE OF D MONTH DECEMBE	DA		YEAR 195	3. TIME OF DEATH A
	4. SOCIAL SECURITY NUMBER 220-16-9324	5. SEX 1 M 2 X F	6. AGE (In yrs. le 78	st birthday) YRS.	IF UNDER	DAYS	IF UNDER	24 HRS. MIN.	7. DATE OF B (Month, Day May 6	(Year)	17	Counto	PLACE (State or Foreign 'yland
e o	9a. FACILITY NAME (If not institution, give st Peninsula General		1	, TOWN	n LOCATI	ON OF DE			9c. COU	DUNTY OF DEATH Wicomico			
DIRECTOR	residence of decedent 100. STATE 100. COUNTY Maryland Son	erset		10c. CIT	Y, TOWN	OR LOCA							10d. INSIDE CITY LIMITS? 1 TYES 2 X NO
FUNERAL	100. STREET AND NUMBER 26421 Burton	Ave.				10	ZIP COO	317			10g. CIT	USA	HAT COUNTRY?
B	11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No— Hyes, specify Cuban, Mexican, Puarto Rican, etc.) 14. RACE — An Black, White									- Amarican Indian, Whita, etc.			
COMPLETED	15. DECEDENT'S EDUC (Specify only highest grade Elementary/Secondery (0-12) Grade 9	CATION completed) College (1-4 or 5) (C	ECEDENT'S Give kind of e. Do NOT u	work done se retired.)	during mo		ng			SINESS/IN	OUSTRY	g.
BE CON	17. FATHER'S NAME (First, Middle, Last) Harold Taylo	r					18. MOT	_	ME (First, Middle Vens		Surname)		
10	19a. INFORMANT'S NAME (Type/Print) Sylvia F. Cleary	(daughte	r)	2642	21 Bu	irto	Ave		Route Number, C	eld,	MD	218	
	20a. METHOD OF DISPOSITION 1 Burtal 2 Cremation 3 Remo			of DISPO	je Me	mor	lal F	ark				Leld,	
	21. SIGNATURE OF FUNERAL SERVICE LIC Robert H. Bra	Sund	'eeul		22.	Brad		1 & 5	sons Fu				D 21817
	23. PART I. Enter the diseases, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, ahock, or heart fallure. List only one cause on sech line.										Approximata interval Batween Onset and Death		
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in deeth) LAST LAND LO PULMONANT ARREST 670 pg LAND LO P												
PHYSICIAN: MEDICAL C	PART II. Other eignificant condition DONTOLD FLEGE D1	FRAG VENSUS	death but not	resulting	In the u	nderlyin	g cauee	given in		YES 2		7 24b.	WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH? 1 YES 2 NO
SICIAN	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 10	HOSPITAL:	☐ ER/Outpatient	3 🗆 DOA	OTHE 4 - Nu	R:			eck only one) 8 Other (Sp	ecify)			
B	27. MANNER OF DEATH 1 Netural 5 Pending Investigation 3 Suicide 8 Could not be determined	26s. PLACE (building	Osy, Year) 13-C15 OF INJURY — At the etc. (Specify)	nome, farm,	JURY M street, fac	1 _	a	NO		N (Street wn, State)	and Number	sta	AUKS Poute Number,
29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner as stated.													
TO BE	30. NAME AND ADDRESS OF PERSON WHY	COMPLETED CAL	SE OF DEATH OF			\ 1.		194			29d. DA	12	2 /9)
	FULIUS ZX	WT	160	7	HI	sid	e D	h	SAL	116	sur	1,1	10815 GY

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BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

HE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within Z4 hours after death. Page 6 may be retained by the hospital or attending physician.	ERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burnal, cremation, or removal.	APORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
TO THE HOSPITAL OF	TO THE FUNERAL DI	be filed within 72 hor	IMPORTANT: If ite

	FOR STATE REGISTRAR	STATE OF MARYL		TMENT OF		MENTAL HYGIEN REG. NO.	E	
	1. DECEDENT'S NAME (First, Middle, Last) Mildred			Hint	on	2. DATE OF DEATH DATE NOV 25		
	4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE (In yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH	8. BI	RTHPLACE (State or Foreign
į	220 – 28 – 0727 9e. FACILITY NAME (If not institution, give		2 YRS.	MONTHS DAYS	OR LOCATION OF DE	ept.14,1		Md Mc DEATH
IOH IOH	Memorial hospi		ton	10	ston		Ta1b	
DIRECTOR	10a, STATE 10b, COUNT		10c, CIT	y, town on Loc Easton	ATION		-	10d. INSIDE CITY LIMITS?
	Md. 100. STREET AND NUMBER	11500			Of, ZIP CODE		10g. CITIZEN (1 XYES 2 NO
ER	27 Locust st				21601		1	U.S.A.
BY FUNERAL	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IF FORCES? 1 YES IF YES, GIVE WAR OR DO	ZY ND	If yes, a	CENDENT OF HISPAN specify Cuban, Maxical S 2 XNO Specify		8	tACE — American Indian, Black, White, etc. Specify: Black
ETED	15. DECEDENT'S EDU (Specify only highest grad	e completed)	16a. DECEDENT'S (Give kind of life. Do NOT us	work done during n	TION nost of working	16b, KIND OF BU	SINESS/INDUSTR	ny .
PLE	Elementary/Secondary (0-12)	College (1-4 or 5+)	Labo			Domes	stic	
COMPL	17. FATNER'S NAME (First, Middle, Last)			1		ME (First, Middle, Maiden		
BE	Willis Hinto	1				izabeth		
2	19a. INFORMANT'S NAME (Type/Print) Gloria Wimber:	1				#9s FLUS		
	20a. METNOD OF DISPOSITION	200	PLACE AND DATE	OF DISPOSITION			CATION — City of	
	1 Burial 2 Cremation 3 Ran 4 Donation 5 Other (Specify)	noval from Stata Cen	OPPERSV	TLLE,	CEME 1	2/8 COP	PERSVI	ILLE,MD.
	21. SIGNATURE OF FUNERAL SERVICE L	CENSEE		Wil1		Fluharty r st. Eas		al Service
AN: MEDICAL CERTIFICATION	IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II, Other significant conditions of the conditions of the conditions of the cause of the ca	a. DUE TO (OR AS A DUE TO (OR	A CONSEQUENCE OF DEATH Y	In the underly	chrining cause given in	Part i. 24a. WAS AN PERFO	AUTOPSY PMED?	Approximate interval Batween Onest and Dasth 'All Floring Company 24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE DF DEATN? 1 YES 2 NO
2	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLACE DF DEA	OTHER:				
PHYSICIAN:	1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending	1 Inpetient 2 ER/Out	28b, T(#	ME OF 26c. I	NJURY AT WORK? YES 2 NO	6 Other (Specify) 26d. OESCRIBE HOW	NJURY OCCURE	D
ED BY	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28s. PLACE OF INJURY building, atc. (Spe				261. LOCATION (Street City or Town, State		ural Route Number,
Signature And Strice 4 Could not be determined building, stc. (Specify) 29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and placa, and due to the cause(a) and manner as stated. 29b. SIGNATURE AND STILE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Ye) 1/2-2-5-5								
	31. DATE FILEO (Month, Day, Year) DEC 0 8 1995	Jun d'Audion	Kardall					

d within 24 hours after death. Page 6 may be retained by the hosp	empletely filled in by the funeral director, page 5 should be detached committee or removal	event, the medical examiner must be notified at once.
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hosp	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached the formal promotion or removal.	be filed within 12 hours after death with the State Dopp. Of regain and mental hygiene prior to done, commone, or sentence must be notified at once. IMPORTANT: If I lem 28 is marked, or litem 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	FOR STATE OF MARYLAND C	DEPARTMENTIFIC			MENTAL HYGIENE REG. NO.						
	1. DECEDENT'S NAME (First, Middle, Lest) STEWART HOWARD		ntum			1995 YEAT					
	4. SOCIAL SECURITY NUMBER 213-22-0154 5. SEX 1 X M 2 F 70	YRS. MO	UNDER 1 YEAR NTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	FEB. 10, 19	925 M	ATHPLACE (State or Foreign Unity) ARYLAND				
TOR	9e. FACILITY NAME (If not institution, give street and number) MEMORIAL HOSPITAL RESIDENCE OF DECEDENT	90	EAST	ON	AIH	TAL	BOT				
DIRECTOR	10e. STATE 10b. COUNTY MARYLAND TALBOT		OWN OR LOCAT			10d. INSIDE CITY LIMITS? 1 YES 2 X NO					
	10e. STREET AND NUMBER			21601			F WHAT COUNTRY?				
Y FUNERAL	8570 SWAN HAVEN ROAD 11. MARITAL STATUS 1 Never Merried 2 Merried FORCES? 1 YES 2 IF YES, GIVE WAR OR DATES	RMED	13. WAS DEC	ENDENT OF HISPAN	IIC ORIGIN? (Specify Yes n, Puerto Rican, etc.)	or No- 14. R.	ACE — American Indian, lack, White, etc.				
COMPLETED BY	(Specify only highest grade completed) (DECEDENT'S US Give kind of work to. Do NOT use re	done during mo	ON st of working	16b. KIND OF BUSI	INESS/INDUSTR' PENTRY	γ				
MPL	11 17. FATHER'S NAME (First, Middle, Last)	CAF	RPENTE		SELI	F EMPL	OYED				
	FRANK ELLSWORTH FRANTUM,	SR.		III-	CECELIA		ıD				
TO BE					Route Number, City or Town						
	20e. METHOD OF DISPOSITION 20b. PLACE	E AND DATE OF E	DISPOSITION (Na	ame of	DATE 20c. LOC	CATION - City of					
		HAVEN			12-8 GLE	N BURN	IIE, MD				
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE B. Kert Phym., CFSP NEWNAM FUNERAL HOME, P.A. 200 S. HARRISON S., EASTON, MD 2160:										
CERTIFICATION	23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiec or reapiratory arrest, shock, or heert failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) Due to (or as a consequence op): Due to (or as a consequence op): Due to (or as a consequence op): Due to (or as a consequence op): Due to (or as a consequence op): Due to (or as a consequence op): Due to (or as a consequence op): Due to (or as a consequence op): Due to (or as a consequence op): Due to (or as a consequence op): Due to (or as a consequence op):										
MEDICAL	PART II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part i. PERFORMED? 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN										
ICIA	25. WAS CASE REFERRED/TO MEDICAL EXAMINER? 1 YES 2 NO		THER:								
BY PHYSICIAN:	27. MANNEY OF DEATH 1 Netural 5 Pending (Month, Day, Year) 2 Accident Investigation	28b. TIME C	OF 28c. (N.	JURY AT DRIK? YES 2 NO	8 Other (Specify) 28d. DESCRIBE HOW IN	I INJURY OCCURED					
	3 Suicide 8 Could not be determined 28e. PLACE OF INJURY — At a building, etc. (Specify)	home, ferm, stre	et, fectory, offic	ce .	28f, LOCATION (Street e City or Town, Stele)	end Number or Rurel Route Number, 9)					
COMPLETED	29e. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. 2 MEDICAL EXAMINER: On the best of axamination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(e) end manner as stated.										
TO BE	296. SIGNATURE AND THTUE OF CERTIFIER HWOULD MD 296. LICENSE NUMBER 296. DATE SIGNED (Morgin, Day, 1987) NULLIAM HWOULD MD 296. LICENSE NUMBER 296. DATE SIGNED (Morgin, Day, 1987)										
	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) WILLIAM H. WOOD, JR., M.D., 506 IDLEWILD AVE., EASTON, MD 21601										
	31. DATE FILED (Month, Day, Year) DFC 07 1995	delle									

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within an after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunal-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

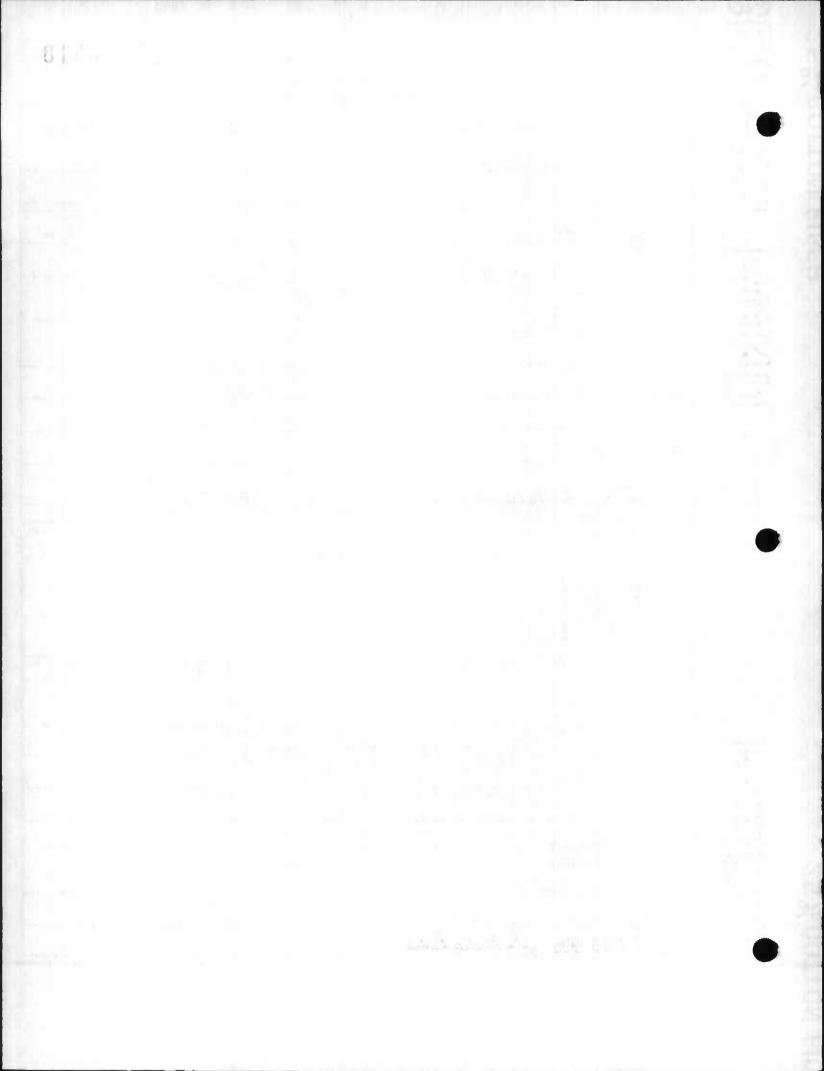
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

1 - FOR STATE REGISTRAR

REGISTRAR											
1. DECEDENT'S NAME (First, Middle, Last							MONT		MY	YEAR	3. TIME OF DEATH
Alexander Ha						7	12		3	95	4:20 pm
4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs.		IF UNDER	1 YEAR	IF UNDER 24 HRS.	7. DATE (Monti	OF BIRTH		8. BIRT	HPLACE (State or Foreign try)
136-01-2925	1 🗆 M 2 🗶 F	93	YRS.					E 25,			SHINGTON
Se. FACILITY NAME (If not institution, give				96. CITY		OR LOCATION OF	DEATH		Sc. COL	INTY OF E	
WILLIAM HILL	MANOR				EA	STON				TAI	BOT
10e. STATE 10b. COUN	ITY		10c. CIT	Y, TOWN C	OR LOCAT	TION					10d. INSIDE CITY
MARYLAND TA	LBOT		1	EAST	ON						LIMITS?
10e. STREET AND NUMBER					101	. ZIP CODE			10g. CI1	TIZEN OF	WHAT COUNTRY?
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11. MARITAL STATUS 1 Never Merried 2 Merried	12. WAS DECEDENT FORCES? 1	T EVER IN U.S.	ARMED			ENDENT OF HISP ecify Cuban, Mexi			a or No-	14. RAC Blac	E — Americen indian, ik, White, atc.
3 Widowed 4 Divorced	FORCES? 1	AR OR DATES	A	1	1 YES	2 NO Spec	elfy:	,		Spec	
16. DECEDENT'S ED	UCATION	15e	DECEDENT'S	I USUAL O	CCUPATIO	DN .	186	. KIND OF BU	CINCOC/IN	DUCTOV	AUTIE
(Specify only highest grade) Elementary/Secondary (0-12)	de completed) College (1-4 or 5+)		(Give kind of life. Do NOT u	work done o	during mo	st of working	100	. KIND OF BO	SHESSIN	DOSINI	
1.2	2		РНОТО	OGRA	PHE	R		РНОТ	OGR	арну	7
17. FATHER'S NAME (First, Middle, Last)			-11020	Join		18. MOTHER'S N	AME (First, I			TAL IX	
WILLIAM HAND	Y					WI	NIFR	ED TA	FT		
19a. INFORMANT'S NAME (Type/Print)			19b. MAILING	ADDRESS	S (Street e	and Number or Rura	/ Route Num	ber, City or Tow	vn, Stelle, Zi	(p Code)	
ALEXANDER H.	HANDY,	JR.	27913	3 PE	ACH	ORCHA	RD R	D., E	EAST	ON,	MD 21601
20e. METHOD OF DISPOSITION	moval Imm State	20b.PLA0	CE AND DATE	OF DISPOS	ITION /Na		DAT		CATION -		
1X Buriel 2 Cremation 3 Re 4 Donation 5 Other (Specify)		GATE	OF I	HEAV	EN		2-9	E.H	IANO	VER,	NJ
21. SIGNATURE OF FUNERAL SERVICE L	LICENSEE					AM FUN		HOME	D	λ	
				I N							
23. PART I. Enter the diseases, or shock, or heart fellure	r complications that	caused tha	death. Do	P 2	00	S. HAR	RISO ch aa card	N ST.	iretory a	ASTC	Approximata interval Between
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mit. Pages 1, 2,	L DIRECTOR	MARYLAND MONTGOMFRY 10e. STREET AND NUMBER		10c. CITY, TOWN OR LOCA				10d. INSIDE CITY LIMITS? 1 YES 2 NO
020 physician. burial-transit pe	FUNERAL	16756 WHITES STORE ROAD	11	~		STATES		
21215-0020 all or attending physician for use as the burial-tra	B	1 Never Married 2 Married FORCES?	NT EVER IN U.S. AI 1 YES 2 W WAR OR DATES	NO If yes, sp	CENDENT OF NISPANI welly Cuban, Mexican, 2 NO Specify:	C ORIGIN? (Specify Yes, Puerto Ricen, etc.)	or No— 14. RAC Blac Spec	E — American Indian, ik, White, etc. WHITE
AND 21215 the hospital or attendetached for use as	COMPLETED	15. DECEDENT'S EOUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5	(0	ECEDENT'S USUAL OCCUPATE Give kind of work done during mo e. Do NOT use retired.) DENTIST	ON pet of working	16b. KIND OF BUS		
5 8 6 E	BE CO	17. FATNER'S NAME (First, Middle, Lest) WALTER HAGEN			18. MOTHER'S HAM MABELLE	FOX	Surneme)	
	10	190. INFORMANT'S NAME (Type/Print) BARBARA H. CUPPS	1	.3000 BRANDON	WAY ROAD	GAITHERS	BURG, MD	
IMOR Page 6 ma I director, p		26. METHOD OF DISPOSITION 1 M Burlel 2 Cremation 3 Removal from State 4 Donation 6 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICENSES			RY 12	2/18/95 G		URG, MD.
P.O. BOX 68760 BA th certificate be executed within 24 nours after of ending physician and completely filled in by the I Hygiene prior to burial, cremation, or removal. or other traumatic event, the medical e	CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Olsease or Injury	R DIACONSE	anoth. Do not enter the mo	BOX 5038 ide of dying, such		TLLE, MA	20882 RYLAND Approximata Interval Between Onset and Death MINUTES YEARS
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DIVISON ATTENDINECTOR OURS after 28	PLETED	3 Suicide 4 Homicide 8 Could not be determined 28a. PLACE building 29a. CERTIFIER (Check only) 1 CERTIFYING PHYSICIAN: To the best of	, etc. (Specny)	ome, farm, street, factory, offic		28f. LOCATION (Street or City or Town, State)		Route Number,
TO THE HOSPITAL (TO THE FUNERAL CE DE fied within 72 h	BE COMPL	one) 2 MEDICAL EXAMINER: On the basis of a				me, date and place, and		
07 07 54 54 54 54 54 54 54 54 54 54 54 54 54	T0	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CALL 10076 DARNESTOWN	SE OF DEATH (ITE		DIG 8.	24	208	
			AR'S SIGNATURE			1 - 11-0		

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

permit. Pages 1. 2, 3 should

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

30. NAME AND ADDRESS OF PER

31. DATE FILED (Month, Day, Year)

DEC

MPLETED CAUSE OF DEATH (ITEM 27) (15/20)

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burla-transit be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burla! cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

									9	5	38420
FOR STATE REGISTRAR	STATE OF M	/ARYLAND /	DEPAR	TMENT O	F HEALTH OF DEAT	AND I	MENTAL	HYGIEN REG. NO			
1. DECEDENT'S NAME (First, Middle	, Lest)				, Dur		2. DATE C				3. TIME OF OEATH
LOU]	ISE JON	IEC					MONTH	D		YEAR	
4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. les	t hirthday)	IF UNDER 1 YE	AR IF UNDER	24 HBS	7. DATE O		30	19951	06:30A " IPLACE (State or Foreign
579-40-6749	1 M 2 Tr	81		MONTHS DA		MIN.	(Month,	Day, Year)	01/	Countr	γ)
9a. FACILITY NAME (If not institution			11.0.	AL DITH TO				20, 1	_		rginia
					WN OR LOCATI		EATH			UNTY OF O	
Prince George	's Hospital			C	heverl	У			Pri	nce (George's
10a. STATE 10b. C	county Cince George	e's		r, TOWN OR L	ocation Height	s					10d. INSIDE CITY LIMITS?
10e, STREET AND NUMBER											TYES 2 NO
					10f. ZIP COO				10g. Cl		VHAT COUNTRY?
6008 Jefferson					2	0743				U.S.	
11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDEN FORCES? 1 IF YES, GIVE V	YES 2 TH	MED	If yo	DECENDENT (e, specify Cube YES 2 NO	n, Maxica	in, Puerto Al		or No-		E — American Indian, k, Whita, atc. thy: Black
15. OECEDENT	'S EDUCATION	16a. OE	CEDENT'S	USUAL OCCU	PATION		16b.	KIND OF BU	SINESS/IN	IDUSTRY	
(Specify only highes Elementary/Secondary (0-12) 12th	collega (1-4 or 5	(G	ive kind of v Do NOT us	vork done durin	g most of worki	ng			riva		
17. FATHER'S NAME (First, Middle, L.	acti		2000			UEO'S MA	ME (Flore 44	iddle, Malden			
Joshua Anth	•				16. MOI		ivia		Surneme)		
19a, INFORMANT'S NAME (Type/Prin	-	1.0				_					
		6	OOO :	ADDRESS (SI	reet and Numbe	or Rural	Route Number	or, City or Tow	n, State, Z	(p Code)	20743 ts, MD
Nelson Jone	25			•		Ignt		_			
20a. METHOD OF DISPOSITION 1 Burlel 2 Cremetion 3 C 4 Donation 8 Other (Specific	Removal from State	cemetery, cre	emetory or of	OF DISPOSITIO		-1	DATE			- City or To	
21. SIGNATURE OF FUNERAL SERV		- IMaryl	and I		al Cem			4 La	urel	, MD	
sambell		coe Tor	ric	J.	B. Je	nkin	s Fun				27. 20705
23. PART i. Enter the disease	a or complications the	t caused the de	anth Do s		74 Lan						
shock, or heert fa	silure. List only one cau	ise on each line	9. OO 1	ior enter the	mode of dy	ing, auc	en se cardi	ec or resp	iratory s	rrest,	Approximate interval Between
IMMEDIATE CAUSE (Final	(0.1	car	1116	116	10-	1	-11	110			Onset and Death
disease or condition resulting in deeth)		GESTI			77	r	-ALI	UNE	2_	1.5	2 46AR
		(OR AS A CONSE			1-11.						12 142120
Constitution to the same state of	C a CI	AROIC	> M	40 11	4747						12 YEARS
Sequentially list conditions, If any, leeding to immediate		(OR AS A CONSE			A 0	Λ			P		10-10
CAUSE (Disease or Injury	. CER	EBRO	VAJ	CUL	AR	AC	40	1200			190A45
thet initiated events	DUE TO	(OR AS A CONSE	OUENCE OF	F):							
resulting in desth) LAST	d										
PART II. Other significant cor	nditions contributing to	deeth but not	resulting	in the under	Tying ceuse	given in	Part I.	24a. WAS AN PERFO		24b	WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
<u> </u>							[1 TYES	NO X		COMPLETION OF CAUSE DF DEATH?
											1 YES 2 NO
DID TOBACCO USE C	ONTRIBUTE TO CA	USE OF DEA	TH YE	S NC	UN(CERTAI	NX				
25. WAS CASE REFERRED TO MEDI				TH (Check only			74				
EXAMINER?	HOSPITAL:	ED/Output	D DOA	OTHER:							
27. MANNER OF DEATH	28a. DATE OF		28b, TIM		Home 5 R	asidence	-		MI III III O	COLUDED	
t Natural 5 Pendin 2 Accident Investig	(Month, E			URY	WORK? YES 2	□ NO	260. DES	CRIBE HOW	INJUNY O	CCURED	
3 Suicide 8 Could datarm	not be building.	OF INJURY — At he, etc. (Specify)	ome, farm,	street, factory,	offica			TION (Street or Town, State		er or Rural I	Route Number
opel	PHYSICIAN: To the best of										
2 MEDICAL E	XAMINER: On the besie of a	Aminimizer and/or	vestigatic	n, in my opini	on, pastn occu	IN THE TOWN	time, deta	end piace, a	nd gua to	tne cause(s	aj and manner sa stated.
29b. SIGNATURE AND TITLE OF CE	FRTIFIER	Atten	Q P	Lyp	29c. LIC	ENSE NU	MBER 1F9	7	29d. D/	I I Z	(Month, Day, Year)
30. NAME AND ADDRESS OF PERS	7209 A	SE OF DEATH (ITE	M 27) (Typo	ARKO	JAY (PRE	BNBE	TT	MO	20-	170

DIVISION OF VITAL RECORD TO THE HOSPITAL, OR ATTENDING PHYSICIAN: The law requires that the LOTHE FUNERAL DIRECTOR. After this certificate has been signed by the Be fled within 72 hours after death with the State Dept. of Heath and IA IMPORTANT: If Hem 28 is marked, or Item 23 shows any Inj.	S, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020	TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	s certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should thin the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.	ed, or item 23 shows any injury, or other traumatic event, the medical examiner must be netified at once.
A 10. 5 pm	DIVISION OF VITAL RECORDS, P.O. BOX 68760	OSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be	UNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the f virbin 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.	ANT: If item 28 is marked, or item 23 shows any injury, or other trau

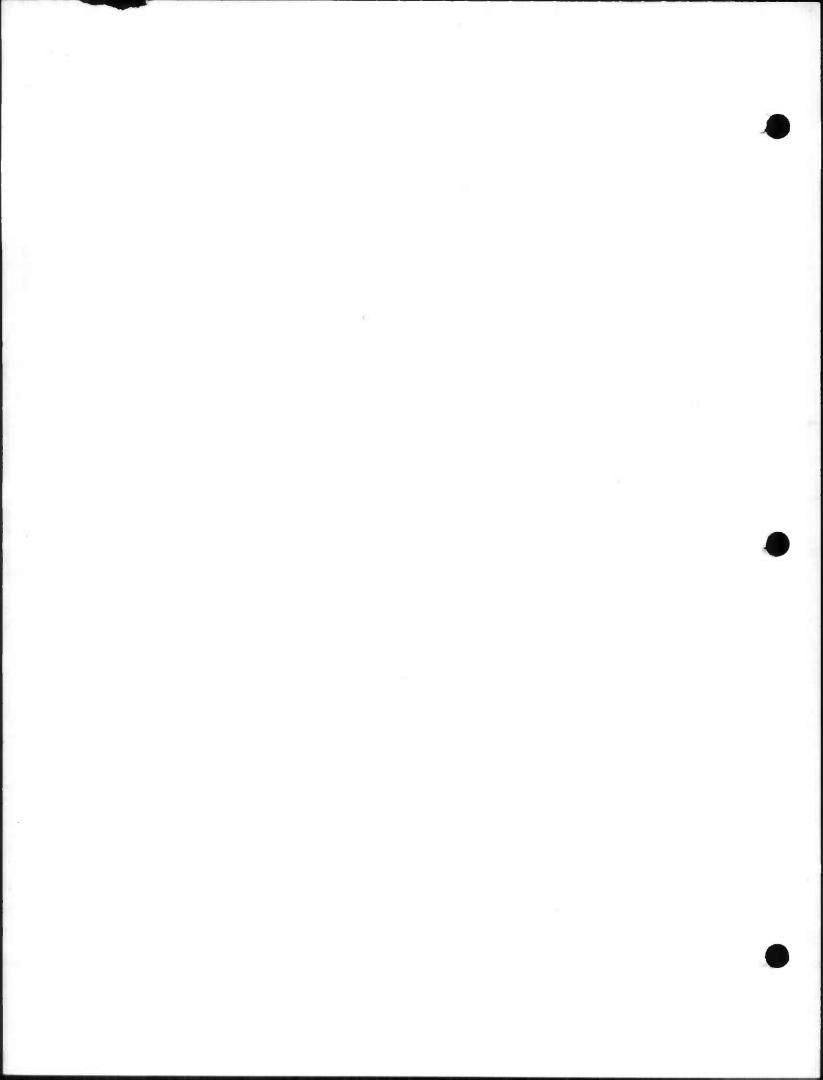
										9	5 3	38421
	1 - FOR STATE REGISTRAR	STATE OF MARY					EALTH DEAT		MENTAL HYGIEN REG. NO	_		
	1. DECEDENT'S NAME (First, Middle, Last)	JOHNS	ion,	Jr.	38 1				0.00	6 19	YEAR 795	5 8.06
	4. SOCIAL SECURITY NUMBER 407-25-8753	5. SEX 6. AC	GE (In yrs. lest	birthday) YRS.	IF UNDER	1 YEAR DAYS	IF UNDER	MIN.	7. DATE OF BIRTH (Month, Day, Year) March 10.	L977	Country	PLACE (State or Foreign y) hio
0"	9s. FACILITY NAME (If not Institution, give str						R LOCATIO	ON OF DE	The state of the s	9c. COU	INTY OF DI	
STOP	Holy Cross Hospi	tal			Sı	Lvei	Spr	ing		Mc	ontgo	mery
DIPECTOR	Maryland Princ	e George's		BOV	Y, TOWN	R LOCAT	ION					10d. INSIDE CITY LIMITS? 1 YES 2 XHO
	10e. STREET AND NUMBER	e dedige s		DOV	ATC	101	. ZIP CODE	E		10g. CIT	IZEN OF W	WHAT COUNTRY?
FUNERAL	15012 Jeremiah						20772					States
BY FUI	11. MARITAL STATUS 1 X Never Merried 2 Married 3 Wildowed 4 Divorced	12. WAS DECEDENT EVE FORCES? 1 Y IF YES, GIVE WAR OF	ES 2 XN	MED IO		If yee, spi			NIC ORIGIN? (Specify Ve in, Puerto Rican, etc.) y:	s or No—	Speci	: — American Indian, r, Whits, etc. fly: Black
LED	15. DECEDENT'S EDUC (Specify only highest grade	CATION completed)	16s. DE(CEDENT'S	USUAL O	CCUPATIO	ON st of workin	ng	166. KIND OF BU	SINESS/IN		
COMPLETED	Elementary/Secondary (0-12)	College (1-4 or 5+)			ge St				Educat	ion		
NOC	17. FATHER'S NAME (First, Middle, Last)						_	HER'S NA	ME (First, Middle, Maiden	Sumsme)		
BE (Gene A. Johnso	n, Sr.						ren	Smith			
10	19a. INFORMANT'S NAME (Type/Print) Gene A. Johnson, Sr. 19b. MAILINO ADDRESS (Street and Number or Pural Route Number, City or Town, State, Zip Co											
	20g. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION — City or Town, State											
	1 X) Burls! 2 Cremetten 3 Removal from State 4 Donation 6 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY											
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Rapp Funeral Services, P. A. 933 Gist Avenue, Silver Spring, MD 20910											
	23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximately an experiment of the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interval onset at disease or condition.											
	resulting in death) a. Que To (or As a conscoulance of):											Suran
N	Sequentielly list conditions,	1 Sepsi	5									Zday
ERTIFICATION	If any, leading to immediate cause. Enter UNDERLYING	- Dely	uati	ASM ASM	OF):							days
LIFIC	CAUSE (Disease or Injury that initiated eventa	DUE TO OR	AS A CONSEC	DUENCE O		- 1						71240
CER	resulting in death) LAST	1. / pave	ac f	4	Ac	100	0212					(any)
MEDICAL	PART it. Other significant condition	a contributing to deal	th but not r	esulting	In the u	ndariyin	g cause (givan in	Part I. 24a. WAS AI PERFO	RMED?	24b	WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH?
	MOY HIS CONT	pesty	OF DEA	TII V	rc 🖂	NO F	7 11116	CEDTAL	15	/\		1 TYES 2 NO
AN	DID TOBACCO USE CONTI	KIBUTE TO CAUSE			ES L	NO L] UNC	ERTAI	N A			
SICI	EXAMINER?	HOSPITAL:	Outpatient 3	□ DOA	OTHE		ne 5 🗆 Re	asidence	6 Other (Specify)			
Y PHYSICIAN:	27. MANNER OF DEATN 1 Netural 5 Pending Investigation	OF DEATN 26e. DATE OF INJURY (Month, Dey, Year) 29b. TIME OF INJURY (Month, Dey, Year)							28d. DESCRIBE NOW	INJURY O	COURED	
TED BY	2/ Accident 3 Suicide 8 Could not be datermined	26e. PLACE OF INJ building, atc. (IURY — At ho (Specify)	ome, farm,	street, fac	tory, offic	28		261. LOCATION (Street City or Town, State	and Numb	er or Rural i	Route Number,
ш	29s, CERTIFIER CERTIFYINO PNYSI	CIAN: To the best of my I	cnowledge, de	with occur	red at the	time, data	and place	s, and du	e to the cause(s) and ma	inner ss st	ated.	
COMPL	Check only One) Check only One) Control only Control on											
BE C	Po SIGNATURE AND TITLE OF CERTIFIED	LV Pin	A AAI	1			29c-LIC	ENSE NU	MBER 327	29d. DA	TE SIGNED	(Month, Day, Year)
0	30. NAME AND ADDRESS OF PERSON WH	O COMPLETED CAUSE O	E DEATH (ITE	M 270 /5-	na Print)		1/	11	・ノフレ		50	0012.

30. NAME AND ADDRESS OF PER SK GWPTX
31. DATE FILED (Morith, Day, Year) 980 Greage Ave #220
32. REGISTRAND SIGNATURE
Julia Standard Randolf

08 1995

ate of executed within 29 hours after useful, rage o may be retained by the hospital of alteroning physicials.	d by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should	prior to burial, cremation, or removal.	d, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
an laile cu	in by the fi	removal.	edicai ex
Rt Z-9 IRON	by filled i	lation, or	the m
nied with	complete	irial, crem	ic event,
וב תב באבר	Sician and	prior to bu	traumat
i cerumos	ending phy	Hygiene	or other
I Ille Deal	by the atte	nd Mental	Injury,
dolles ma	rtificate has been signed I	he State Dept, of Health and A	nows any
le idw re	has bee	Dept.	n 23 sl
SICIAN: The law requir		the State	or iter
JING PHTS	OR: After this c	e filed within 72 hours after death with I	arke
ALLENI	ECTOR	s after	1 28 1
A UH	THE FUNERAL DIRECTOR	2 hour	'f item
COPILA	UNERA	ithin 7,	WILL
U THE H	O THE FL	e filed w	MPORTA

	FOR 1 - STATE REGISTRAR	STATE OF MARY	LAND / DEPARTM			MENTAL	HYGIEN			
	DECEDENT'S NAME (First, Middle, Last) RODNEY	LEON		ies, Ji		2. DATE MONTE DECE	OF DEATH	ĭ,1995	3. 4	TIME OF DEATH
	4. SOCIAL SECURITY NUMBER 229-52-1212	5, SEX 6. AGE	(In yrs. last birthday) III	F UNDER 1 YEAR ONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE (Month	OF BIRTH , Day, Year)	8.	BIRTHPLA Country)	CE (State or Foreign
5	98. FACILITY NAME (If not institution, give s THE JOHNS I	ntreet and number) HOPKINS HOSP			IMORE CI			9c. COUNTY	of DEAT	н
DIRECTOR	10a. STATE 10b. COUNT	v Lingham		own on Loca	TION					1. INSIDE CITY LIMITS? YES 2 NO
LONELAK	100. STREET AND NUMBER 245 College St	reet		10	H. ZIP CODE 22821					tates
5	11. MARITAL STATUS 1 Never Merried 2 X Merried 3 Widowed 4 Divorced	12. WAS DECEDENT EVER FORCES? 1 ₩ YES IF YES, GIVE WAR OR 1960-1966	2 NO	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Maxican, Puerto Rican, etc.) 1 YES 2 NO Specify: Specify:					American Indien, hite, etc.	
	15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12)		16a. DECEDENT'S US (Give kind of work life. Do NOT use n	k done during m	ION ost of working	16b.	KIND OF BUS	SINESS/INDUS	TRY	
COMPLEIED	8		Truck	Driver				ng Ind	lustr	у
	17. FATHER'S NAME (First, Middle, Last) Rodney Leon Jones	s. Sr.			18. MOTHER'S NA Ruth			Surname)		
	19a. INFORMANT'S NAME (Type/Print)		19b. MAILING AS	DDRESS (Street	and Number or Rural	Route Numb	ber, City or Town	n, State, Zip Co	de)	
-	Debra Lambert Jo	nes	245 Co.	llege	Street, D	ayto			228	
	20e. METHOD OF DISPOSITION 1 M Burlel 2 Cremation 3 Ram 4 Donation 5 Other (Specify)	noval from Stata	ob. PLACE AND DATE OF ametery, crematory or other Lastlawn Me	morial	cember 4, Gardens	199	5 Har	cation — city risonb	urg,	Virginia
	21. SIGNATURE OF FUNERAL SERVICE LIE	P. Kulta	M00348	Home/	nd address of fa Bethesda- nsin Ave.	-Chev	y Chas	se, Inc		y Funeral 7557 1-3501
	23. PART I, Enter the disease, or shock, or heart failure. IMMEDIATE CAUSE (Final disease or condition resulting in death)	List only oha cause on	aach line.			h aa carc	diac or respl	ratory arrest	9	Approximate Interval Between Onset and Death
CENTIFICATION	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST CAUSE (Disease or injury that initiated events resulting in death) LAST CAUSE (DISEASE OF INJURY CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):									
	Champail Hockey Viel. Profunder and Dix Classe					24s. WAS AN AUTOPSY PERFORMED? 1 VES 2 NO		CC	RE AUTOPSY FINDINGS AILABLE PRIOR TO MPLETION OF CAUSE DEATH? YES 2 PNO	
		NTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN								
	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO	HOSPITAL:		THER:		100				
	27. MANNER OF DEATH	26e. DATE OF INJURY	7 28b. TIME (OF 28c. II	JURY AT	7		NJURY OCCUP	NED	
2 Accident Investigation							Rural Rout	e Number,		
3 Suicide 6 Could not be determined building, atc. (Specify) 29a. CERTIFIER (Check only only) 2 MEDICAL EXAMINER: On the best of examination end/or investigation, in my opinion, death occurred at the time, data and placa, and due to the cause(a) and menner as										
		ER: On the beels of exeminet							ause(a) ar	nd manner as stated.
	29b. SIGNATURE AND TITLE OF CERTIFIE	nen M.O. Re	sident in S	- 1	29c. LICENSE NU	MBER 6	2		IGNED IM	onth, Day, Year)
2	30. NAME AND ADDRESS OF PERSON WE GOON. WOLK ST	t. 605 Blah	uk Buly	nini)	MO	21	205			
31. DATE FILED (Month, Day, Year) DF C 04 1995 July Deutster (August 1995)										



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AL RECORDS,	law requires
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4	The
OF V	PHYSICIAN
SICIN	ATTENDING F

		FOR STATE REGISTRAR	STATE OF MARYLAND	/ DEPARTME			MENTAL	HYGIENE REG. NO.		
		1. DECEMENT'S NAME (First, Middle, Last)		Johns	n	, , , , , , , , , , , , , , , , , , ,	MONTH	Sept Day	GYEAR S	510P M
1/1		579-94-3848 a	SEX 6. AGE (In yrs. 24	YRS. MONT		IF UNDER 24 HRS. HOURS MIN.	(Month,		Washi	ngton, DC
, 2, 3 should	TOR	9a. FACILITY NAME (If not institution, give street Prince Georges Comm	NATIONAL PROPERTY.			erly, Mar			ince G	Georges
it. Pages 1	DIRECTOR	Maryland Prince	Georges	10c. CITY, TOW		Heights,	Mary	yland		IOd. INSIDE CITY LIMITS? YES 2 NO
physician. burial-transit permit. Pages 1,	FUNERAL	10s. STREET AND NUMBER 2089 Addison Road	South		101	20747				States
	BY FU	11. MARITAL STATUS 1 Never Merried 2 Married 3 Widowed 4 Divorced	. WAS DECEDENT EVER IN U.S. FORCES? 1 YES 2 IF YES, GIVE WAR OR DATES		If yes, sp	endent of HISPAN ecify Cuben, Mexica 2 NO Specify	n, Puerto Ri	(Specify Yea or No-ican, stc.)		- American Indian, Whita, etc. : Black
or attend	COMPLETED	15. DECEDENT'S EDUCATI (Specify only highest grade com Elementary/Secondary (0-12)		DECEDENT'S USUA (Give kind of work do life. Do NOT use retire	one during mo id.)	st of working	16b.	KIND OF BUSINESS/IN	IDUSTRY	DIACK
the hospital or detached for	COMPI	17. FATHER'S NAME (First, Middle, Last)	3-		N/	16. MOTHER'S NA		N/A		
retained by 5 should be notified at	TO BE	Wesley Johnson, S 190. INFORMANT'S NAME (Type/Print) Les Johnson	DE -			and Number or Rural i	Route Numbe	nderson or, City or Town, State, Z ict Hgts.		20747
ay be		20e. METHOD OF DISPOSITION 1 □ Burlel 2 ♣ Cremetion 3 □ Removal 4 □ Donation 5 □ Other (Specify)	from State 20b. PLA cemetery, Me 1	CEANDDATEOFDIS crematory or other plant	POSITION (No	ame of	DATE		- City or Tow	n, State
death. Page tuneral din f.		21. SIGNATURE OF FUNDAM, SERVICE LICENS	m 1		Alex	ander S.	Pope	Funeral ce Forestv	Homes	
certificate be executed within 24 hours at diging physician and completely filled in by Hygiene prior to burial. cremation, or remrer other traumatic event, the medicine other traumatic event,	RTIFICATION	23. PART I. Enter the diseasea, or comehock, or heart failure. Lief IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	only one cause on each i	ISEQUENCE OF):				nch VISU	,	Approximata Interval Between Onset and Death
law requires that the death law requires that the death so been signed by the attence of Health and Mental H 23 shows any injury, or	MEDICAL CE	1 YES 2 TO OF DEATH? 1 YES 2 NO								AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
ate hate	SICIAN:		26, P OSPITAL:	PLACE OF DEATH (CH	eck only one)					
PHYSICIAN: The this certificate with the State	PHYS	27. MANNES OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	26b. TIME OF	28c. IN.	JURY AT DRK?		CRIBE HOW INJURY O	CCURED	
OR ATTENDING PHYSICIAN: OR ATTENDING PHYSICIAN: DIRECTOR: After this certifica hours after death with the St Item 28 Is marked, or It	ED BY	2 Accident Investigation 3 Suicide 8 Could not be 4 Homicide determined	N/A 28e. PLACE OF INJURY — A building, atc. (Specify)	N/A t home, ferm, street,		YES 2 X NO		N/A TION (Street and Number Town, State)	er or Rural Ro	oute Number,
- R III	MPLET		N: To the best of my knowledge on the bests of examination and	, death occurred at				se(a) and manner as st	ated.	and manner as stated
TO THE HOSPITAL OF THE FUNERAL DE FIED WITHIN 72 ho	BE CO	200. SIGNATURE AND TITLE OF COMMITTEE	upuz mr.	2		D212				Month, Day, Year) 7 3 , 1995
9	10	Dr. Augusto P. Rod	1	(ITEM 27) (Type, Print) 5009 Rayl	ourn (Ct.,Camp	Sprin	ngs, Md.		
Ø		31. DATE FILED (Month, Day, Year) DEC • 8 1995	32. BEGISTRAD'S SIGNATUR					<u> </u>		

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 28 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If Nem 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.
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	1 - FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPAR CERTIFI				D MEN	ITAL HYGIEN				
	1. DECEDENT'S NAME (First, Middle, Last)							ATE OF DEATH			3. TIME OF DEATH	
	Bradley Sylvester	Jackson, Sr						cember		YEAR	4:30 p	м
	4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE (I	In yrs. lest birthday)	IF UNDER 1 Y		IF UNDER 24 HR	8. 7. 0	ATE OF BIRTH		. BIRTH	PLACE (State or Foreign	gn
		1 😡 M 2 🗆 F 📗 8 C	YRS.	MONTHS D	AYS F	HOURS MIN		cober29,	1915	Vir	ginia	
	9a. FACILITY NAME (If not institution, give street			9b. CITY, TO	WN OR	LOCATION OF	DEATH		9c. COUNT			\neg
DIRECTOR	4142 Bunker Hill Ro	oad # 404		Cotta	ge (City			Prince	e Ge	eorge's	
E C	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY		10c. CITY	, TOWN OR L	OCATIO	IN .				I	10d, INSIDE CITY	
PIC	Maryland Prince	e George's		tage							LIMITS?	
7	10e. STREET AND NUMBER	5 000180 5	1 000	cage	-	Y CIP CODE			10a. CITIZE	EN OF W	1 X YES 2 NO	_
ER/	4142 Bunker Hill 1	Road # 404			21	0722				5.A.		
FUNERAL	11. MARITAL STATUS	12. WAS DECEDENT EVER IN	U.S. ARMED	13. WAS	DECEN	DENT OF HIS	PANIC OI	RIGIN? (Specify Yes			- American Indian, White, atc.	-
BY F	1 Never Married 2 Married 3 Widowed 4 Divorced	FORCES? 1 YES				Ify Cuban, Mai		rto Rican, atc.)			y: Afro-	
											ican	
TEI	15. DECEDENT'S EDUCAT (Specify only highest grade co	TION Impleted)	(Give kind of w	ork done duris				16b. KIND OF BU	SINESS/INDU	STRY		
J.E	Elementary/Secondary (0-12)	College (1-4 or 5 +)	life. Do NOT use	,								- 1
COMPLETED	17. FATHER'S NAME (First, Middle, Last)		Steelwor	ker	17	to MOTHERIO	114145 (5	Steel I		СУ		_
E	Unknown						know		Sumame)			- 1
0	19a. INFORMANT'S NAME (Type/Print)		19b. MAJLINO	ADDRESS (S	treet and			Number, City or Tow	n State 7in C	Soutia I		
5	Bradley S. Jackson,	.Ir.						Washing			20001	-1
	20a. METHOD OF DISPOSITION	20h	PLACE AND DATE O						CATION — CI			
	1 N Burial 2 Cremation 3 Removi	001111	etery, cremetory or off		mort	ial Da		/9/05 T	a			- 1
	21 SIGNATURE OF FUNERIAL SERVICE LICEN	ISEE	. Nation									
	11191	10 (1)	. 1					Sons Fu				
	23. PART I. Enter the diseases, or cor	mplications that coused	the death. Do no	Ra T	time mode	ore Av	enue	Hyatt	ratory arres	M. M	Approximate	
	ahock, or heart fallure. Lis IMMEDIATE CAUSE (Final	at only one causa on es	ich line.								Interval Betw Onset and D	reen
	disease or condition resulting in death)	Tertemople	witer &	sule	m	10001	1	duca	u -	-		
	Total (in data(ii)	DUE TO (OR AS A	CONSEQUENCE OF):		- qui					1	-
Z	Secure Maller Heat are alleled to b.											
E	Sequantially list conditions, if any, leading to immediate	DUE TO (OR AS A	CONSEQUENCE OF):					_			
2	CAUSE (Disease or Injury	DUE TO 100 40 4									_	
E	that initiated events resulting in death) LAST	DUE TO (OR AS A	CONSEQUENCE OF):								
CERTIFICATION	d											-
AL	PART II. Other algnificant conditions	contributing to death bu	ut not reaulting in	the under	rlying c	ceuse given	In Part	24s. WAS AN		24b.	WERE AUTOPSY FINDS	NGS
2	Ethy liem							1 TYES 2		+	AVAILABLE PRIOR TO COMPLETION OF CAUS OF DEATH?	BE
ME				/						1	1 YES 2 NO	- 1
ż	DID TOBACCO USE CONTRI	BUTE TO CAUSE OF	F DEATH YES	NO		UNCERT	AIN []				
PHYSICIAN: MEDIC	25. WAS CASE REFERRED TO MEDICAL EXAMPLER?	HOSPITAL:	26. PLACE OF DEATI		one)							
YSI	1 PYES 2 NO 1	☐ Inpatient 2 ☐ ER/Outpu		OTHER: 4 - Nursing	Home	5 Rasiden	De 6 🗆	Other (Specify)				
H	27. MANNER OF DEATH 1 Netural 5 Pending	(Month, Day, Year)	28b. TIME INJU		. INJUR WORK		28d.	DESCRIBE HOW I	NJURY OCCU	RED		
BY	2 Accident Investigation					5 2 NO						
E	3 Suicide 8 Could not be 4 Homicide detarmined	28e. PLACE OF INJURY building, atc. (Speci	— At home, farm, at f(y)	reet, lectory,	office		281.	LOCATION (Street a City or Town, State)	and Number or	Runal R	oute Number,	
<u> </u>	- 10											
MP	(Check only	AN: To the best of my knowle										- 1
COMPLET	2 MEDICAL EXAMINER:	On the basis of exemination	and/or investigation	, in my opini	on, daat	th occured at	the time,	deta and place, an	d dua to the	cause(s)	and manner as state	d.
BE	29b. SIGNATURE AND TITLE OF CERTIFIED	011			15	9c LICENSE I	NUMBER		DATE S	BIGNED	(Month, Day, Year)	\neg
2	Migusto /X	sangua	m		H	1013	32		steces	M	47,19	27
	AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF DEA	TH (ITEM 27) (Type,	Print)	1	1.	. 11	11	C	1	N TITT	
	31. DATE FILED (Month, Day, Year)	wiguest	50	79/	any	pus	n(L CA	. 07	NI	48 207	4
	NFC 8 1995	Jahra Daves	ATURE COLL		/		•	,			- 7	

individual sale (CEEE)

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	CONTAIN ON ATTENDIAN DUNCHOLAND The Contract that the death contains the contract of the contr
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DIVISION OF VITAL RECORDS, P.O. BOX 68760	8
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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR 1 -CERTIFICATE OF DEATH 1. OECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH Jones obert VOV. 1435 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR B. BIRTHPLACE (State or Foreign IF UNDER 24 HRS. 7. DATE OF BIRTH 7. DATE OF BIRTH (Month, Day, Year) 221208881 1 XM 2 | F 85 YAS. DAYS HOURS Pages 1, 2, 3 should 9a. FACILITY NAME (# not institution, give 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF GEATH Dorcheter General Caruspidge, Hospital DIRECTOR Dorchester RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Rhodesdale Dorchester 1 X YES 2 NO permit. 100. STREET AND NUMBER FUNERAL 21659 10g. CITIZEN OF WHAT COUNTRY? 5551 Sharptown Road funeral director, page 5 should be detached for use as the burial-transit retained by the hospital or attending physician. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or NoIf yea, specify Cuben, Mexican, Puerto Rican, etc.)

1 YES 2 NO Specify: 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Married BY Specify 3 Widowed 4 Divorced White COMPLETED 15. OECEDENT'S EDUCATION (Specify only highest grade complete 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5+) Forestry 0 ahorer once. 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Surname) William Jones Ħ Sadie (maiden Name unknown) BE notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILINO ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Lillian Harrison 5551 Sharptown Rd. Rhodesdale, Md. 21659 must be 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION -- City or Town, State Eldorado Cemetery 4 Donalion 5 Other (Specify) _ 11/26/95 Eldorado, Md. examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Williamson Funeral Home Federalsburg, Md. completely filled in by the the medical 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart feliure. List only one cause on each line. Interval Betwe cremation, or IMMEDIATE CAUSE (Fine) Onset and Death disease or condition DUE TO (OR AS A CONSEQUENCE OF): resulting in death) injury, or other traumatic event, to burial, o Phenmonia CERTIFICATION pue Sequentielly list conditions, DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate attending physician been signed by the attending physician it, of Health and Mental Hygiene prior cause. Enter UNDERLYING CAUSE (Diseese or injury that initiated events DUE TO (OR AS A CONSEQUENCE OF): resuiting in death) LAST PART II. Other aignificant conditions contributing to deeth but not resulting in the underlying cause given in Part i. MEDICAL 24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE 24s. WAS AN AUTOPSY shows any Chronic 1 - YES 2 NO OF OEATH? fracture Acute of. left hip 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES 🔀 NO 🗌 UNCERTAIN 🗆 PHYSICIAN: has b 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF OEATH (Check only one) certificate t HOSPITAL: OTHER: 1 TYES 2 NO Monpetient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 8 Other (Specify) ò 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT 28d. DESCRIBE HOW INJURY OCCURED this c marked, 1 Natural 2 Accident 5 Pending 1 YES 2 NO BY After investigation DIRECTOR: An hours after desirem 28 is n 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 4 Homicide TO THE HOSPITAL DR ATT TO THE FUNERAL DIRECT be filed within 72 hours at IMPORTANT: If item 2 COMPLET 29a, CERTIFIER 1 Y CERTIFYINO PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated. on and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(a) and manner as stated. 296. SIGNATURE AND TITLE OF CERTIF 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE 2 LETED CARSE OF DEATH (ITEM 27) (Type, Print) Edward Lauph1.2 31. DATE FILEO (Month, Day, Year) 32, REGISTRAR'S SIGNATURE Tales Davidson Rarlall DEC 08 1995

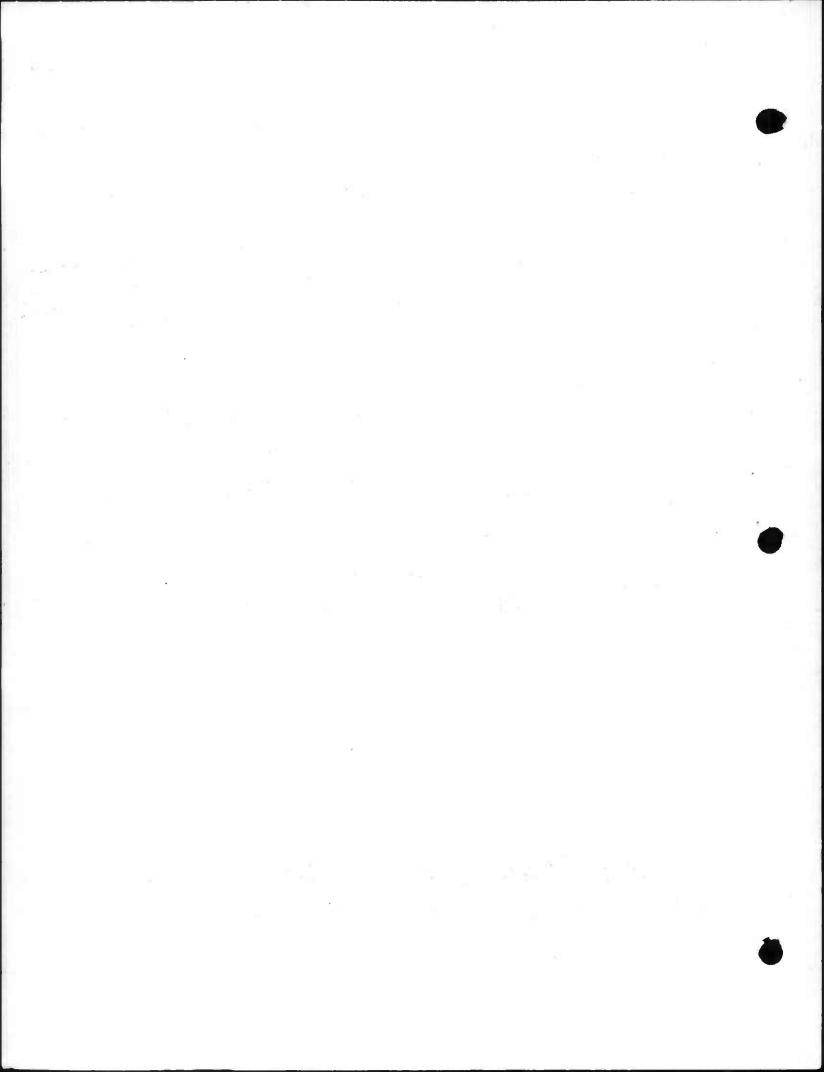
BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, Page 6 may be retained by the hospital or attending physician. THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit pages 1, 2, 3 should be detached for use as the burial-transit permit pages 1, 2, 3 should be detached for use 2, 3 should be detached for use 3 should b	
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STATE OF	MARYLAND /	DEPARTMENT	OF HEALTH	AND	MENTAL	HYGIENE
	CE	ERTIFICATE	OF DEAT	ГН		BEG NO

	1 - FOR STATE REGISTRAR	STATE OF MARY	LAND / DEPARTI			NTAL HYGIEN		00420
	1. DECEDENT'S NAME (First, Middle, L	ast)			2.	DATE OF DEATH		3. TIME OF DEATH
	Elizabett	Sweeny	~ 10	005	1	MONTH ON	7 1994	
	4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE		F UNDER 1 YEAR		DATE OF BIRTH	8, BI	RTHPLACE (State or Foreign
	216-05-5241 9a. FACILITY NAME (If not institution, s		2 YRS.	ONTHS DAYS	D	ec 20, 1	912 Ma	ryland
DIRECTOR	Bon Secours Ext	tended Care Fa	1	Ellicot	t City		9c. COUNTY O	
ည္က	10e. STATE 10b. CO		10c. CITY, T	OWN OR LOCAT	ON			10d. INSIDE CITY
		Howard	Co	lumbia				1 YES 2 X NO
FUNERAL	10e. STREET AND NUMBER			101.	ZIP CODE			OF WHAT COUNTRY?
ᄬ	6028 Cedarwood	Drive 12. WAS DECEDENT EVER	MILE ADMED	1 40 444 0 000	21044			d States
BY FL	1 Never Married 2 Married 3 Widowed 4 Divorced	FORCES? 1 YES	2 XNO	If yes, spe	endent of Hispanic Colfy Cuban, Mexican, Po 2 NO Specify:	ORIGIN? (Specify Yea uarlo Rican, etc.)		IACE American Indian, llack, White, etc.
	15. DECEDENT'S	EDUCATION	16a. DECEDENT'S US	UAL OCCUPATIO	N	16b. KIND OF BUS	INESS (INDI ISTE	White
COMPLETED	(Specify only highest (Elementary/Secondary (0-12)		(Give kind of work life. Do NOT use n	done during mos	t of working	160. KIND OF BUS	SINESS/INDUSTR	*
ᆲ	Living your control y (0-12)	2	Adminis	trative	Asst.	Educat	ion	
Š	17. FATHER'S NAME (First, Middle, Last	n			18. MOTHER'S NAME (
ш	Clarence Sweer	ly			Jesse D	esmone Ke	eith	
9	19a. INFORMANT'S NAME (Type/Print)		19b. MAILING AD	DRESS (Street ar	d Number or Rural Route	Number, City or Town	n, State, Zip Gode)	
-	Patricia J. Mah	ıle	6028 C	edarwoo	d Drive	Columbia	, Maryl	and 21044
	20a. METHOD OF DISPOSITION 1 □ Burlal 2 Cremation 3 □	Removal from State Ca	b. PLACE AND DATE OF C	DISPOSITION (Nat	ne of	DATE 20c. LO	CATION — City or	Town, Slata
1	4 Donation 5 Other (Specify)	B	metery, crematory or other alt—Washin				urel, M	aryland
	21. SIGNATURE OF FUNERAL SERVIC	E LICENSEE			H. Witzke		Home	Inc
	Shem a.	Collisso						t City 21043
	23. PART i. Enter the diseases,	or complications that ceuse ure. List only one ceuse on	d the deeth. Do not	enter the mod	le of dying, auch as	cerdiac or reapl	ratory arrest,	Approximata
	iMMEDIATE CAUSE (Fine)							Interval Between Onset and Death
ĺ	disease or condition resulting in death) a. PREUMONIA							Iwa
z	Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): SWALLOWING DISORDER DUE TO (OR AS A CONSEQUENCE OF):							HILMON !
2	Sequentially list conditions, if any, leeding to immediate	DUE TO (OR AS	A CONSEQUENCE OF):					
5	cause. Enter UNDERLYING CAUSE (Disease or injury	" HTTH	EIMER	NE	MENTI	H		IOYRS
HIFICATION	that initiated events resulting in death) LAST	DUE TO (OR AS	A CONSEQUENCE OF):					
SER		d		-				
AL.	PART ii. Other aignificent condi	itions contributing to death	but not resulting in t	he underlying	ceuse given in Pari	i. 24a. WAS AN	AUTOPSY 2	24b. WERE AUTOPSY FINDINGS
	•					PERFOR	MED?	AMAILABLE PRIOR TO COMPLETION OF CAUSE
MEDIC						. /		OF DEATH?
	DID TOBACCO USE CO	NTRIBUTE TO CAUSE O	OF DEATH YES	□ NO □	UNCERTAIN E	1		
PHTSICIAN:	25. WAS CASE REFERRED TO MEDICA EXAMINER?		26. PLACE OF DEATH					
2	1 TES 2 NO	HOSPITAL: 1 Inpetient 2 ER/Out	patient 3 DOA 4	Nursing Home	5 Residence 6	Other (Specify)		
5	27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME O			. DESCRIBE HOW IN	JURY OCCURED	
5	1 Natural 5 Pending 2 Accident Investigati	on			ES 2 NO			
3	3 Suicide 6 Could not 4 Homicide determine	building, etc. /Spe	Y — At home, farm, street offy)	et, fectory, office	261	LOCATION (Street a City or Town, State)	nd Number or Run	al Route Number,
OMPLE	29a, CERTIFIER 1 CERTIFYING PI	HYSICIAN: To the best of my know	wladon dareh nazional a			on Carantana and	Charles and Carlo	
<u> </u>		MINER: On the beals of examination						o/s) and meaner on stated
د	29b. SIGNATURE AND TITHEFOR CERT	nutr () () ()	. 0		20-41051/65 1441			
	Man 1	Woll &	MI		10299	09		MBER 27, 1995
	SCOTT MAUR	FL 950 OLC		ns RO	FULCOTT	- CVTY 1	no 2	1047
	31. DATE FILED (Month, Day, Year)	22. BEGISTRAR'S SIGN	HATURE					
	NOV 2 8 1995	Julia Devoleon Ra	rdall					



BALTIMORE, MARYLAND 21215-0020

Pages 1, 2, 3 should

TO BE COMPLETED BY FUNERAL DIRECTOR

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TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

		STATE OF MAR				HEALTH AND I DEATH	MENTAI	REG. NO.				
1. DECEDENT'S NAME (First, I	Widdle, Last)				===		2. DATE	OF DEATH		3.	TIME OF DE	ATH
WILLIAM		V.		KRAME	R		DECI	MBER "	, 199	5°	1:25	р. м
4. SOCIAL SECURITY NUMBER	R 5.1	SEX 6.	AGE (In yrs. la:		IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE	OF BIRTH	8.	BIRTHPLA	CE (State or	
022-16-2356	^	M 2 F	78	YRS.	MONTHS DAYS	OR LOCATION OF DE	MARC	H 10,			CTICU	JT
MANOR C					CHEVY		CAIN		MONTO			
RESIDENCE OF DECI					CHEVI	CHASE			MONT	JOHEL	(1	_
10a. STATE	10b. COUNTY			10c. CITY,	TOWN OR LOC	ATION				104	d. INSIDE CI	TY
MASS.	NORFOL	.K		Qt	JINCY					1 {	YES 2	NO NO
10a. STREET AND NUMBER					1	Of. ZIP CODE			10g. CITIZEI	N OF WHA	T COUNTRY	,
33 BRACKETT	STREET					02169			UNIT	ED ST	CATES	
11. MARITAL STATUS 1 Never Married 2 1		FORCES? 1			13. WAS DI	CENDENT OF HISPAN	NIC ORIGIN	7 (Specify Yes	or No 14	. RACE - Black, W	American in hita, atc.	dlan,
3 Never married 2 1 1		IF YES, OIVE WAR				S 2 X NO Specif		, , , , , ,		Specify:	r m m	
15 DECE	DENT'S EDUCATION			CEDENT'S	JSUAL OCCUPA	CION	140	. KIND OF BUS	INECC INCLE	WH]	LTE	
(Specify only	highest grade comp	pleted)	(0	live kind of wi	ork done during r	nost of working	100	. KIND OF BUS	INESS/INDUS	IPCT		
Elementary/Secondary (0-	(2) Co	ollege (1-4 or 5+) 5+			ATRIST			MEDIC	INE			
17. FATHER'S NAME (First, Mic	Idle. Last)					18. MOTHER'S NA	MF (First					
SAMUEL	KRAMER					LENA		INGOLD				
19a. INFORMANT'S NAME (Ty	pe/Print)		19	b. MAILING	ADDRESS (Stree	and Number or Rural				ocle)		_
STEVEN KRAME	R (SON	1)				ECK CT.,					910	
20a, METHOD OF DISPOSITIO	ON				F DISPOSITION (DAT		ATION — CIT			
1 [XBuriel 2 - Cremation 4 - Donation 5 - Other (from State	SHAR	NO MEN	MORTAL	PARK	12/		RON, I			ETTS
21. SIGNATURE OF EUNERAL	SERVICE LICENS	EE A	-			NSKY-GOL	KRED C					
1	1	/_ /			1170	ROCKVILL	DREK(MEMOR	CENTE	HAPEI	LS, I	NC.
23. PART i. Enter the dis	~~	plication that as	-	ath Do n						-		
ahock, or he	art failure. List	Dnly Dne cause	on each lin	в.								Batween
IMMEDIATE CAUSE (Fine disease or condition	il	12:	1 1	00	, PI	2	01	/			Onaet a	nd Death
resulting in death)	* a_	DUE TO (OR	AS A CONSE	OLIENCE OF	C 1/ 1/2	eura e		russ	in		24	NO
	_	mo	425	tak	- 6	bural d	Œ,		/		6m	-
Sequentially list condition			AS A CONSE):	2 -400	-u	nces				~
cause. Enter UNDERLYIP	VG											
	VG	DUE TO (OR	AS A CONSE	OUENCE OF):							
Cause. Enter UNDERLYIF CAUSE (Disease or Injur	y	DUE TO (OR	AS A CONSE	OUENCE OF):	~						
cause. Enter UNDERLYIF CAUSE (Disease or Injur that initiated eventa resulting in death) LAST	d											
cause. Enter UNDERLYIP CAUSE (Disease or Injur that initiated events	d					ng cause given in	Part i.	24a. WAS AN PERFOR		AM	ERE AUTOPSY	OR TO
cause. Enter UNDERLYIF CAUSE (Disease or Injur that initiated events resulting in death) LAST	d					ng cause given in	Part I.		MED?	AM CC		OR TO
cause. Enter UNDERLYIF CAUSE (Disease or Injur that initiated events resulting in death) LAST PART II. Other significan	d	ontributing to de	nth but not	reaulting lo	n the underly			PERFOR	MED?	OF	MPLETION O	F CAUSE
cause. Enter UNDERLYIF CAUSE (Disease or Injur that initiated eventa resulting in death) LAST PART II. Other aignifican DID TOBACCO US	oddseconditions co	ontributing to de	E OF DEA	resulting lo	n the underly	UNCERTAI		PERFOR	MED?	OF	AILABLE PRIC IMPLETION OF DEATH?	F CAUSE
Cause. Enter UNDERLYIP CAUSE (Disease or Injurthat initiated eventa resulting in death) LAST PART II. Other aignificer DID TOBACCO US 25. WAS CASE REFERRED TO EXAMINER?	ot conditions co	ONTITUTE TO CAUS	E OF DEA	reaulting I	n the underly	UNCERTAI		PERFOR	MED?	OF	AILABLE PRIC IMPLETION OF DEATH?	F CAUSE
Cause. Enter UNDERLYIF CAUSE (Disease or Injurthet initiated eventa resulting in death) LAST PART II. Other aignifican DID TOBACCO US 25. WAS CASE REFERRED TO EXAMINER? 1 YES 2 NO	ot conditions co	OSPITAL:	E OF DEA	TH YE	S NO H (Check only or THER: Nursing He	UNCERTAI	N D	PERFOR 1 YES 2	MED?	AM CO DF	AILABLE PRIC IMPLETION OF DEATH?	F CAUSE
Cause. Enter UNDERLYIF CAUSE (Disease or Injurthet initiated events resulting in death) LAST PART II. Other significant DID TOBACCO US 25. WAS CASE REFERRED TO EXAMINER? 1 YES 2 1 NO 27. MANNER OF DEATH	ot conditions co	ONTITUTE TO CAUS	E OF DEA	reaulting I	NO H (Check only or Nursing H	UNCERTAI	N D	PERFOR	MED?	AM CO DF	AILABLE PRIC IMPLETION OF DEATH?	F CAUSE
Cause. Enter UNDERLYIF CAUSE (Disease or Injur that initiated events resulting in death) LAST PART II. Other aignificant DID TOBACCO US 25. WAS CASE REFERRED TO EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Return 5 6	of c	OSPITAL: Inpettent 2 EF 28e. DATE OF INJ (Month, Day, V	E OF DE/ 26. PLA (/Outpetient URY	TH YE CE OF DEAT 3 DOA 28b. TIME	S NO H (Check only or OTHER: DF Varieng M 1 28c. I	UNCERTAI o) ome 5 Gesidence NJURY AT VORK? VES 2 NO	8 Other	PERFOR 1 YES 2 or (Specify) SCRIBE HOW II	MED?	AM CO	AILABLE PRIMINETION OF DEATH? YES 2	F CAUSE
Cause. Enter UNDERLYIP CAUSE (Disease or Injur that initiated eventa resulting in death) LAST PART II. Other aignificar DID TOBACCO US 25. WAS CASE REFERRED TO EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 9 2 Accident 1 3 Suicide 8 0	odd	ONTRIBUTING TO DESCRIPTION OF THE TO CAUS	E OF DE/ 26. PLA //Outpetient URY bar/ JURY — A1 h	ATH YE. CE OF DEAT 3 DOA 28b. TIME	S NO H (Check only or OTHER: DF Varieng M 1 28c. I	UNCERTAI o) ome 5 Gesidence NJURY AT VORK? VES 2 NO	8 Other 28d. DE:	PERFOR 1 YES 2	MED?	AM CO	AILABLE PRIMINETION OF DEATH? YES 2	F CAUSE
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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

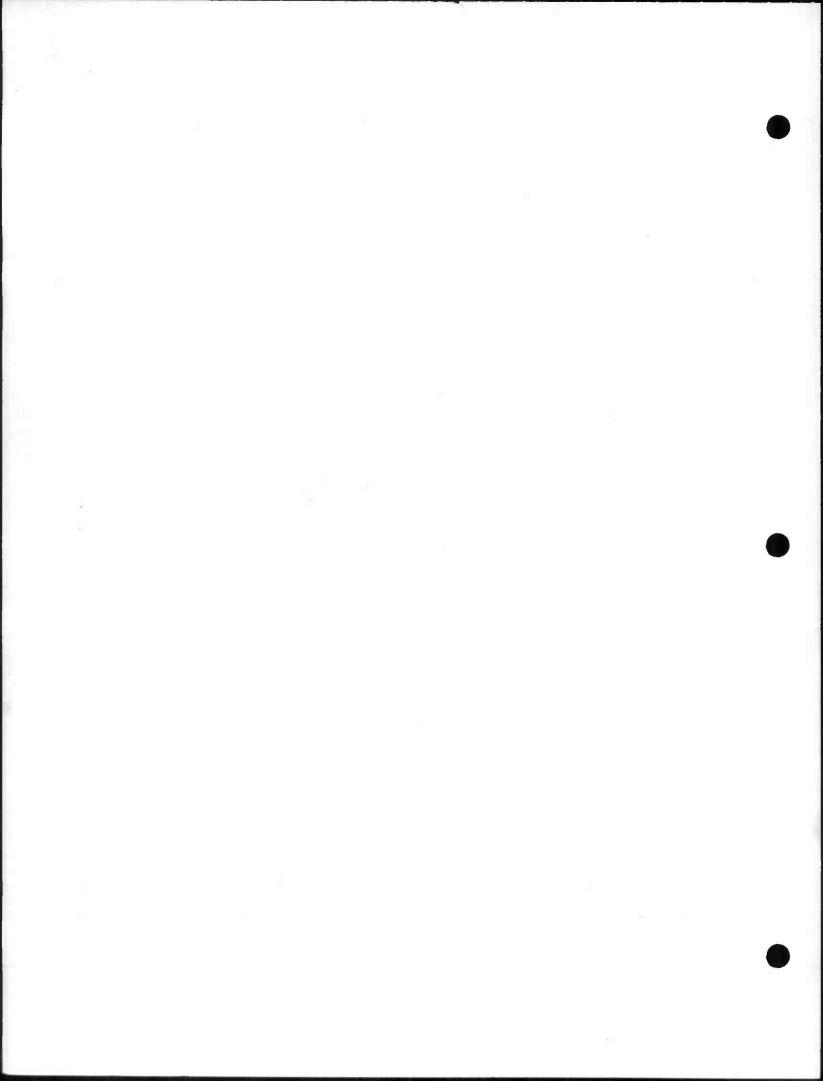
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

STATE	0F	MARYLAND	/ DEPARTMENT	0F	HEALTH	AND	MENTAL	HYGIEN	E
		C	ERTIFICATE	0	F DEAT	TH		BEG NO	

	FOR STATE REGISTRAR	STATE OF MARYL		TMENT OF I		MENTAL HYGIE				
,	DECEDENT'S NAME (First, Middle, Linst) RAYMOND	PAUL		KEIGH		2. DATE OF DEATH MONTH NOVEMBER		3. TIME OF DEATH 08:28A M		
	4. SOCIAL SECURITY NUMBER		(In yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH		RTNPLACE (State or Foreign		
	213-48-5334	1 🔯 M 2 🗆 F		MONTHS DAYS	HOURS MIN.	(Month, Day, Year)	Co	.950 Washington, D.C.		
~	9a. FACILITY NAME (If not institution, give str			OR LOCATION OF DI		9c. COUNTY O	F DEATN			
DIRECTOR	THE JOHNS HOPKINS HOSPITAL			BALT	IMORE CI	TY	N	lone		
<u>교</u>	10a. STATE 10b. COUNTY			, TOWN OR LOCA	TION			10d. INSIDE CITY		
듬	Maryland Mo	ntgomery	1		Potoma	C		1 YES 2 V NO		
	10e. STREET AND NUMBER	7		10	I. ZIP CODE		10g. CITIZEN C	F WHAT COUNTRY?		
E	9401 Reach	Road			208	54	Unite	d States		
BY FUNERAL	11. MARITAL STATUS 1 Never Married 2 Merried 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IF FORCES? 1 YES IF YES, GIVE WAR OR DA	2 X NO	If yes, sp		NIC ORIGIN? (Specify) in, Puarto Rican, atc.) y:	ea or No— 14. R	or No— 14. RACE — American Indian, Bleck, White, stc. Specify:		
<u>a</u>	15. DECEDENT'S EDUC		16a. DECEDENT'S	USUAL OCCUPATI	ON	16b. KIND OF B	USINESS/INDUSTR	White		
<u> </u>	(Specify only highest grade of Elementary/Secondary (0-12)	College (1-4 or 5+)	life. Do NOT us	ork done during mo e retired.)	ost of working					
릴		5+	Pr	esident		Floo	ring Com	pany		
COMPLETED	17. FATNER'S NAME (First, Middle, Last)				IR. MOTNER'S NA	ME (First, Middle, Maide				
BE		ond Michael	Keigher			Muri	el Evers			
0	19a. INFORMANT'S NAME (Type/Print)					Route Number, City or To				
	Karen A. Keighe					mac, Mary				
	20a, METNOD OF DISPOSITION 1 [X] Burial 2 Cremation 3 Ramo 4 Donation 5 Other (Specify)	val from State 20b	petery cremetory or of H	per place) Dec	ember 2,	1995 20c. 1	OCATION — City o			
	21. SIONATURE OP TUNERAL SERVICE LICE		Jale OI n	22. NAME A	emetery ND ADDRESS OF FA	CILITY S1.	lver Spr	ing, Maryland		
	· 10000	Zal +	M00335	Rober	t A. Pum sda-Chev	phrey Fund y Chase, da, Maryl	eral Hom Inc. 755	e/ 7 Wisconsin 4-3501		
	23. PART I. Enter the diseases, or or	mplications that cause	d the death. Do n		ode of dylng, suc	h as cardiac or res	piratory arrest,	Approximata		
- 1	shock, or heart fellure. L IMMEDIATE CAUSE (Final	ist only one ceuse on e	ach line.					Onaet end Death		
	disease or condition resulting in death)	CONSEQUENCE OF		2 days						
		DUE TO (OR AS	CONSEQUENCE OF	7):						
z	Sequentially list conditions,	Renal	failure					6 months		
CERTIFICATION	If any, leading to immediate cause. Enter UNDERLYING	DUE TO (OR AS A	CONSEQUENCE OF	7):				F 440 - 0		
윤	CAUSE (Diseese or Injury	DUE TO (OR AS A	CONSEQUENCE OF):	-			1 year		
Ē	that initiated eventa resulting in death) LAST	Henet	itis B	,				10 years		
8	- 0	lichei						1.5/55		
Y.	PART II. Other significent conditions	contributing to deeth b	out not reaulting i	n the underlyin	g ceuse given in		ORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO		
음						1 YES	2 NO	OF DEATN?		
M								1 🗆 YES 2 🐧 NO		
Ä	DID TOBACCO USE CONTR	IBUTE TO CAUSE O				NA				
PHYSICIAN: MEDIC	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLACE OF DEAT	OTHER:						
4	1 TYES 2 NO 27, MANNER OF DEATH	1 Inpatient 2 ER/Outs 28a, DATE OF INJURY	28b, TIMI		JURY AT	8 Other (Specify) 28d. DESCRIBE NOV	IN ILIEN OCCUBE			
	1 Natural 5 Pending	(Month, Day, Year)			ORK?	200. DESCRIBE NOV	INSONT OCCURE	·		
BY	2 Accident Investigation 3 Suicide 8 Could not be	28e. PLACE OF INJURY building, etc. (Spec	/ — At home, term, a	trset, factory, offic	:0	281. LOCATION (Street		rel Route Number,		
COMPLETED	4 Nomicide determined	buttoning, etc. (Spot	City)			City or Town, Sta	re)			
1 5	29a. CERTIFIER (Check only)	CIAN: To the best of my know	riedga, death occurre	d at the time, date	and place, and du	to the cause(a) and n	nanner aa stated.			
MO	one)	a: On the beels of examination						se(e) and menner se stated.		
	29b, SIGNATURE AND TITLE OF CERTIFIER				29c. LICENSE NU	MBER	29d. DATE SIG	NED (Month, Day, Year)		
BE	Mark Levis	MD			M6321		Novem	iber 30, 1995		
일	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF DE	ATN (ITEM 27) (Type,	Print)						
	Mark Levis Joh	ns Hopkins	Hospital	600 Nor	th Wolfe	Street B	altimore	Maryland		
	31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGN	ATURE			, , ,	1			
	DEC 04 1995	Jalia Davels	ortania							





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RECORDS,
VITAL
OF
DIVISION

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH 1995 November 29 9:00P Danis Grey IVNCH 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH (Month, Day, Year)
July 2, IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign 1 M 2 F 579-42-4625 HOURS 63 YRS: 1932 Virginia Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH Hospital DIRECTOR Doctor's Prince George's Lanham RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c CITY TOWN OR LOCATION 10d. INSIDE CITY Maryland Prince George's Upper Marlboro 1 X YES 2 NO permit. 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 121 Harry S. Truman Drive #31 use as the burial-transit 20772 U.S.A. retained by the hospital or attending physician. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No—
If yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. RACE — American Indian, Black, White, etc. BALTIMORE, MARYLAND 21215-0020 1 Never Merried 2 Merried 1 TES 2 NO Specify: Black Specify: BY 3 Widowed 4 Divorced ETED 16e. DECEDENT'S USUAL OCCUPATION 15. DECEDENT'S EDUCATION ecity only highest grade complete 16b. KIND OF BUSINESS/INDUSTRY (Spe (Give kind of work done during life. Do NOT use retired.) be detached for College (1-4 or 5+) COMPL 12th Supervisor Private once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Meiden Surneme) William T. Gray, Sr. Ħ Mattie Braxton BE funeral director, page 5 should notified 19e. INFORMANT'S NAME (Type/Print) 19b. MAILINO ADDRESS (Street end Number or Rural Route Number, City or Town, State, Zip Code) 2 LaFondra Jackson 10509 Meadowlake Terrace, Mitchellville, MD 20721 death. Page 6 may be 9 20s. METHOD OF DISPOSITION
15 Burlel 2 Cremetion 3 Removal from State 20c. LOCATION — City or Town, State 20b. PLACE AND DATE OF DISPOSITION /Name of OATE must ty Buriel 2 ☐ Cremetion 3 ☐ r 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Cemetery | 1 12/4 Suitland. examiner 21. SIGNATURE DE FUNERAL SERVICE LICENSEE J. B. Jenkins Funeral Home 7474 Landover Road, Landover, MD 20785 n and completely filled in by the to burial, cremation, or removal. hours after medical 23. PART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death IMMEDIATE CAUSE (Final the disease or condition RECURRENT HETASTATIC BREAST 3 YEARS resulting in death) DUE TO (OR AS A CONSEQUENCE OF) EFFUSION MALIGNENT PLEVRAL traumatic HONTH CERTIFICATION Sequentially list conditions. DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate signed by the attending physician Health and Mental Hygiene prior to death certificate be cause. Enter UNDERLYING ACUTE RESPIRATORY DISTRESS SYNDROME WEEK CAUSE (Disease or Injury other DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 6 injury, PART II. Other aignificant conditions contributing to deeth but not resulting in the underlying ceuse given in Part i. the MEDICAL 24a, WAS AN AUTOPEN 24b. WERE AUTOPSY FINDINGS PERFORMED AMILABLE PRIOR TO requires that ашу COMPLETION OF CAUSE OF DEATH? 1 TYES 2 NO shows 2 1 YES 2 NO t. of t DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \(\Boxed{1}\) NO \(\Boxed{N}\) UNCERTAIN \(\Boxed{1}\) has b Dept. PHYSICIAN: S 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) certificate I HOSPITAL:
1) Inpatient 2 - ER/Outpetient 3 - DOA 1 YES 2 54 NO DR ATTENDING PHYSICIAN: 4 Nursing Home 5 Residence 8 Other (Specify) 6 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? this c 284. DESCRIBE HOW INJURY OCCURED marked, 1 Natural 5 Pending М 1 YES 2 NO BY After death Investigation 2 Accident 28e. PLACE OF INJURY — At home, farm, etreet, factory, office building, etc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Yourn, State) 69 DIRECTOR: / COMPLETED 8 Could not be 4 🔲 Homicide 82 determined item 29e. CERTIFIER 1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(e) end manner ee stated. FUNERAL within 72 h HOSPITAL =TO THE HOSPITA
TO THE FUNERA
De filed within 72
IMPORTANT: II 2 🗌 MEDICAL EXAMINER: On the basic of exemination end/or investigation, in my opinion, death occurred at the time, date end piece, end due to the ceuse(e) end menner ee stated. 29b. SIGNATURE AND TITLE OF CENTIFIES 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE 130/95 D43162 ► 11 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

Dr. Melvin Gaskins 12164 Central Avenue Mitchellville, MD

32. 9EGISTRAR'S SIGNATURE



31. DATE FILED (Month, Day, Year)

DEC

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

O THE HOSPITAL, OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	OTHE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	MPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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	FOR STATE REGISTRAR	STATE OF MARYL		ARTMENT OF		MENTAL HYGIEN			
,	1. DECEDENT'S NAME (First, Middle, Last)		1 1			2. DATE OF DEATH		3.	TIME OF OEATH
	MARJORIE	5,	LLO	4D		DECEMBER		195	2 PH
	4. SOCIAL SECURITY NUMBER		(In yrs. last birthde	MONTHS DAYS		7. DATE OF BIRTH (Month, Day, Year)		8. BIRTHPLA Country)	MCE (State or Foreign
į	220-44-5793		3 YRS			Feb. 26,			Indiana
œ	9e. FACILITY NAME (If not institution, give street end number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH								
DIRECTOR	Suburban Ho	spital			Bethesda		<u> </u>	lontgo	omery
R	10a. STATE 10b. COUNTY	1	10c.	CITY, TOWN OR LO	ATION			100	d. INSIDE CITY LIMITS?
	Maryland Mo		Bethesda					1 TYES 2 NO	
FUNERAL	10e. STREET AND NUMBER				IOI. ZIP CODE		10g. CITIZEN OF WHAT COUNTRY?		
N.	10216 T	yburn Terrac		40 1110 0		814			States
	1 Never Married 2 Married	FORCES? 1 YES	2 X NO	li yes,	specify Cuben, Mexic	NIC ORIGIN? (Specify Ye an, Puerto Rican, atc.)	s or No—	Black, W	American indian, Title, etc.
ВУ	3 🔀 Widowed 4 🗌 Divorced	IF YES, GIVE WAR OR D	PATES	1 1 4	S 2 NO Speci	fy:		Specify:	White
ED	15. DECEDENT'S EDU (Specify only highest grade	CATION completed)	16e, DECEDEN	T'S USUAL OCCUPA of work done during	TION	16b. KIND OF BU	SINESS/INDU		
COMPLETED	Elementary/Secondery (0-12)	College (1-4 or 5+)	life. Do NO	T use retired.)	nost of Working				
MP		2	Но	omemaker			wn Hor	ne	
	17. FATHER'S NAME (First, Middle, Last)	. 1				AME (First, Middle, Meiden			
BE	Jerome W	Malter Spark		INC ADDRESS (Stand		rtle Loui:			
2	Marcia Jean Ty	rre11				ane Bethese			2001/
1	204 METHOD OF DISPOSITION						CATION — C		
ì	1 X Burlei 2 Cremation 3 Rem 4 Donation 5 Other (Specify)	oval from State cer	Park 1	or other place) De	cember 5,	1995 20c. LG			Maryland
	21. SIGNATURE OF FUNERAL SERVICE LIC	CENSEE	2 00 2 2 2 2	22. NAME	ANO ADORESS OF F	ACILITY	. 1 77	/	lar y rang
	1 /2 C) X al x	W0027	Bethe	sda-Chev	y Chase, Inda, Maryla	nc. 75	\$57 Wi	isconsin
	23. PART I. Enter the diseases, or	complications thei ceuse	M0033	o not enter the r	node of dying, suc	th se cardiec or reap	iratory arm	314-35 eat,	Approximate
	ahock, or heert feilure. IMMEDIATE CAUSE (Finel	List only one cause on	eech line.						Interval Between Onset and Death
		a. ANOXIC OUE TO (OR AS	ENCE	MALOPAT	WY				2 DAYS
N	Sequentially list conditions,	D. CARDIAC							20AYS
AŢ	if any, leading to immediate cause. Enter UNDERLYING			ULAN 1	ICALE				UNKNOWN
FIC	CAUSE (Disease or Injury that initieted events	c. DUE TO (OR AS			1)EA)E				Challan
CERTIFICATION	resulting in death) LAST	d							
	PART II Other simillions condition	to contribution to doubt	hus and mould	and the sectories	lan samul labour to	B-41 1-1 11-11			
CAL	PART ii. Other significant condition	s contributing to death	out not resultil	ng in the underly	ing ceuse given ir	PERFO	RMED?	AM	ERE AUTOPSY FINDINGS AILABLE PRIOR TO DMPLETION OF CAUSE
ED					,	1 TYES	2 NO	OF	DEATH?
Σ	DID TOBACCO USE CONT	PIRLITE TO CAUSE O	DE DEATH	YES NO	UNCERTAI			1 [TES 2 NO
IAN	25. WAS CASE REFERRED TO MEDICAL	The cause of		DEATH (Check only or					
Sic	EXAMINER?	HOSPITAL:	patient 3 🗆 DO	OTHER:	ome 5 🗆 Rasidence	8 Other (Specify)			
PHYSICIAN: MEDIC	27. MANNER OF OEATH	28s. OATE OF INJURY (Month, Day, Year)	28b.		NJURY AT WORK?	28d, OESCRIBE HOW	INJURY OCC	URED	
BY §	1 Natural 5 Pending 2 Accident investigation	(manufacty)			YES 2 NO				
ED	3 Suicide 6 Could not be	26s. PLACE OF INJUR building, etc. (Spe	Y — Ai home, iar	m, atreet, fectory, or	fice	28i. LOCATION (Street City or Town, State		or Rural Route	e Number,
ETE	4 Homicide detarmined								
COMPLET	onel	ICIAN: To the best of my known ER: On the bests of examination							nd manner es stated,
EC	29b. SIGNATURE AND TITLE OF CERTIFIE	1 1-		-	29c. LICENSE NU	IMBER	29d. DATE	SIGNED (Me	onth, Day, Year)
TO BE	Meus a &	to COMPLETED CAUSE OF O	EATH /ITEM 27) /	Time Donell	04131	(1		2/3/9	75
	YUNI A- O	EYCHAKM.D.	6410 F		Drive #2	200 Bethes	da,Mar	yland	1 20817
	31. DATE FILEO (Month, Day, Year) DEC 07 1995	32. REGISTRAR'S SIG	NATURE						
									DHMH-18 Rev 1/89

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BALTIMORE, MARYLAND 21215-0020 hours after death. Page 6 may be BOX 68760

575-64-5472 1 🕅 M 2 🗌 F use as the burial-transit permit. Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number, 8033 CREST ROAD DIRECTOR RESIDENCE OF DECEDENT 10b. COUNTY HOWARD LAUREL 10a, STREET AND NUMBER FUNERAL 8033 CREST ROAD retained by the hospital or attending physician. 5 should be detached for use as the burial-tran 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 XNO IF YES, GIVE WAR OR DATES 1 Never Married 2 Married BY 3 Widowed 4 Divorced COMPLETED 15. DECEDENT'S EDUCATION (Specify only high Elementary/Secondary (0-12) College (1-4 or 5+) 12 17. FATHER'S NAME (First, Middle, Last) JOHN NAKANELUA LOO ĕ BE notified 19a. INFORMANT'S NAME (Type/Print) 2 MARGARET L. LOO funeral director, page 5 9 20a METHOD OF DISPOSITION
1 DI Burlei 2 Offengtion 3 Removal from State
4 Donation 5 Other (Specify) must medical examiner 21. SIGNATURE/OF FUNERAL SERVICE LICENSEE emmons signed by the attending physician and completely filled in by the Health and Mental Hygiene prior to burial, cremation, or removal. shock, or heert failure. List only one ceuse on each line. IMMEDIATE CAUSE (Finel the disease or condition reaulting in deeth) event. requires that the death certificate be executed HODGKINS NON traumatic CERTIFICATION Sequentially list conditions. OUE TO (OR AS A CONSEQUENCE OF) If any, leading to immediate Cause Enter LINDERLYING CAUSE (Diseese or Injury other DUE TO (OR AS A CONSEQUENCE OF) DIVISION OF VITAL RECORDS, P.O. that initiated events resulting in death) LAST MEDICAL shows any Health a been to of PHYSICIAN: has be Dept. 23 HOSPITAL OR ATTENDING PHYSICIAN: The law 25. WAS CASE REFERRED TO MEDICAL ltem. certificate h HOSPITAL OTHER: 1 YES 2 NO Inpatient 2 - ER/Outpatient 3 - DOA marked, or 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF with with 1 Maturel 5 Pending BY After t 2 Accident TO THE HOSPITAL OR ATTENDING TO THE FUNERAL DIRECTOR: Afte be filed within 72 hours after deal IMPORTANT: If item 28 is m 3 Suicide COMPLETED 6 Could not be 4 Homicide BE 2

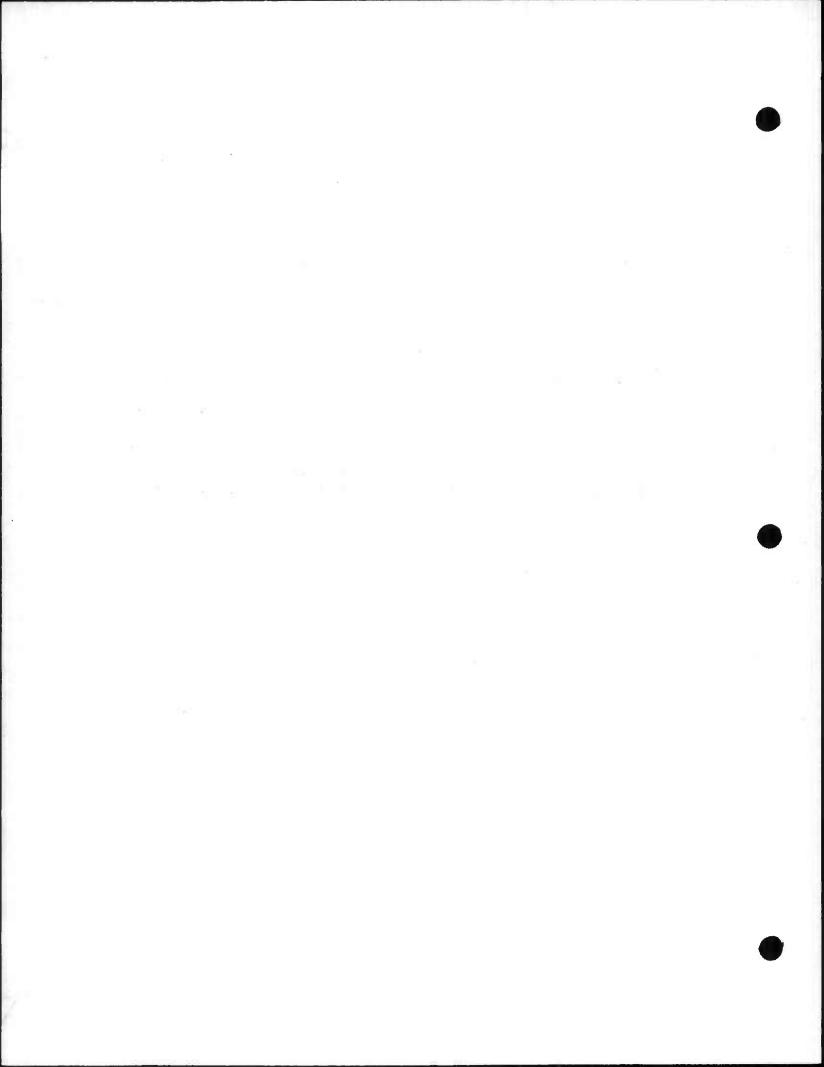
04 1995

Julia Davidson Render

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Lest) 2. DATE OF DEATH 3. TIME OF DEATH JEFFREY KALIMA LOO NOV 1 9595 11:15 P M 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. lest birthday) IF UNDER 1 YEAR 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign IF UNDER 24 HMS. (Morith, Day, Yea EB 14 FEB HAWAII 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH LAUREL HOWARD 10c, CITY, TOWH OR LOCATION 10d. INSIDE CITY 1 YES 2 NO 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 20723 USA WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or Noif yes, specify Cuben, Maxican, Puerto Rican, etc.)
 U YES 24 NO Specify: 14. RACE — American Indian, Black, White, stc. caŭĉasian/asian 16s. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 18b. KIND OF BUSINESS/INDUSTRY DIRECTOR OF HUMAN RESOURCES HOTEL INDUSTRY 16. MOTHER'S NAME (First, Middle, Maiden Surname) MARGARET RODRIOUES 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. BOX 1497 HONOKAA, HAWAII 20b. PLACEAND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State OATE KUKUTHAELE COUNTY CEM. HILO, HAWAII 12/14 22. NAME AND ADDRESS OF FACILITY JOSEPH GAWLER'S SONS, INC. 20016 \$130 WISCONSIN AVE, N.W.WASHINGTON, D.C. 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, Interval Batween Onset and Death CARDIO PUL MONARY ARREST DUE TO (OR AS A CONSEQUENCE OF): 10 41N LYMPHOMA 2 MO PART II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? PERFORMED? 1 TES 2 340 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \square NO \square UNCERTAIN \square 26. PLACE OF DEATH (Check only one) 4 Nursing Home 5 Sesidence 6 Other (Specify) 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 YES 2 NO 28a. PLACE OF INJURY — At home, farm, streat, tectory, office building, stc. (Specify) 28t. LOCATION (Street and Number or Rural Route Number City or Town, State) 29a. CERTIFIER
(Check only one)

2 MEDICAL EXAMINES: On the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and menner as stated. 2 MEDICAL EXAMINER: On the besis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 29 LICENSE NUMBER 29d. DATE SIGNEO (Month, Day, Year) 87/68 12/4 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) RICHARD CHAISSON 600 N. WOLFE ST, BALTO, MD 32. BEGISTRAR'S SIGNATURE

DHMH-16 Rev 1/89



Pages 1, 2, 3 should

permit.

be detached for use as the burial-transit

funeral director, page 5 should

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1995

Julia Davidson Rarchall

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	TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within the hours after	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or remova	IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical
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FOR STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REGISTRAR CERTIFICATE OF DEATH REG NO 1. DECEDENT'S NAME (First, Middle, Lest 2. DATE OF DEATH MONTH 3. TIME OF DEATH RUTH HELEN LIBBEY 1995 December 9:26 PM 4. SOCIAL SECURITY NUMBER 5 SEY 8. AGE (In yrs. last birthday) IF UNDER 1 YEAR 7. DATE OF BIRTH (Month, Day, Year) 8. BIRTHPLACE (State or Foreign IF UNDER 24 HRS. HOURA 1 M 2 X F 66 YRS. 219-48-9243 April 929 Rhode Island 9s. FACILITY NAME (If not institution, give street and number, 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Montgomery General Hospital 01ney Montgomery 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Silver Spring Montgomery 1 N YES 2 NO FUNERAL 10e STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 15321 Baileys Lane 20906 United States 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 XNO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-14. RACE — American Indian, Black, White, etc. FORCES? 1 YES 2 1 Never Married 2 Married It yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 YES 2 XNO Specify: BY 3 Widowed 4 X X Divorced Specify: White COMPLETED 16a. DECEDENT'S USUAL OCCUPATION 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16b. KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5 +) 12 4 Assistant to the Bishop Episcopal Church once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Malden Sumame) F Melvin Hazard Brightman Helen Davis BE notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILINO ADDRESS (Street and Number or Rural Route Number, City or Town, Stets, Zip Code) 2 Laura Libbey 15321 Baileys Lane, Silver Spring, Maryland 20906 2 20a. METHOD OF DISPOSITION
1 Department of Street S 20c. LOCATION — City or Town, State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE must Fort Lincoln Crematory 4 Donation 12/4 8 Other (Specify) Brentwood, Maryland 21. SIGNATURE OF FUNERAL SERVICE LICENSI examiner 22. NAME AND ADDRESS OF FACILITY Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Ave., Silver Spring, MD medical 23. PART t. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, ahock, or heart failure. List only one cause on each line Interval Between IMMEDIATE CAUSE (Final Onset and Death the disease or condition CARDIOMYU SCHEMIC resulting in death) traumatic event, DUE TO (OR AS A CONSEQUENCE OF CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CON If any, leading to immediate METES MELLIM! cause. Enter UNDERLYING CAUSE (Disease or injury other t DUE TO (OR AS A CONSEQUENCE OF) that initiated eventa reaulting in death) LAST 6 Injury. PART II. Other algoliticent conditions contributing to deeth but not resulting in the underlying cause given in Part I. MEDICAL 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH? PERFORMED? shows any 1 | YES 2 | NO 1 TES 2 DAG DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO WINCERTAIN PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) Hem. HOSPITAL OTHER: 1 | YES 2 | NO Inpatient 2 R/Outpatient 4 Nursing Home 5 Residence 8 Other (Specify) 6 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT 28d. DESCRIBE HOW INJURY OCCURED marked. 1 Natural 5 Pending М 1 YES 2 NO BY 2 Accident 28s. PLACE OF INJURY — At home, term, atreet, tectory, office building, etc. (Specify) 3 Sulcide 8 Could not be 28t. LOCATION (Street and Number or Rural Route Number, City or Town, State) .09 COMPLETED 4 Homicide 28 ltem mean 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On ition, in my opinion, death occured at the time, data and place, and due to the cause(a) and manner as stated. PECEMBER 2, BE 2 V. Gorsa 31. DATE FILED (Month, Day, Year)

DHMH-16 Rev 1/89

TO BE COMPLETED BY FUNERAL DIRECTOR

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TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.	companional of the condition on these man fabrica on white action the condition accompanion control has control to condition of the	五海 医 3
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1 - FOR STATE REGISTRAR	S	TATE OF MARYL		MENT OF H		MENTAL	HYGIENE BEG. NO.			
1. DECEDENT'S NAME (First,	Middle, Last) nold	м.	hyor			2. DATE WONTH	OF DEATH	9.14	3. TIME OF DEATH	
4. SOCIAL SECURITY NUMB 329-26-2513	78	M 2 □ F 62	YRS.	F UNDER 1 YEAR HONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	12-	of BIRTH 30–32	G	HTNPLACE State of Foreign	
Prince Georgesidence of Dec	ges Coun			ob. city, town of Cheve	r LOCATION OF DI	county	Georges			
10a. STATE Md.	10b. COUNTY Monto	omerv	755.22	town or locat	ION			10d. INSIDE CITY LIMITS? Yes 2 No		
100. STREET AND NUMBER 11804 Milbern Dr.					01. ZIP CODE 10g			g. CITIZEN OF WHAT COUNTRY?		
11. MARITAL STATUS 1 Never Married 2 Married 3 Wildowed 4 Divorced 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES KOrean				It yes, sp-	ENDENT OF NISPAL Belty Cuban, Mexico	an, Puerlo F	17 (Specify Yea or N Rican, etc.)		RACE — American Indian, Black, White, etc.	
15. OEC (Specify onli Elementary/Secondary (0	EDENT'S EDUCATION IN PROPERTY OF THE PROPERTY	ollege (1-4 or 5+)	16a. DECEDENT'S U (Give kind of wo life. Do NOT use	ork done during mo retired.)		16b.	RIND OF BUSINES		RY.	
17. FATNER'S NAME (First, M	Lyons					AME (First, A	Middle, Maiden Surns		Rodzinski	
190. INFORMANT'S NAME (I		ons	19b. MAILING A				ber, City or Town, Sta			
20s METHOD OF OISPOSIT 1 Buriel 2 Crematic 4 Donation 5 Other	n 3 🗌 Removal		PLACE AND DATE OF	d Memor	al Gard		2/3 Fa:	11s C	hurch, Va.	
21. SIGNATURE OF FUNERA	L RUVICE LICENS	EE		Edwai 1091	d Sage1 Rockvil	Fune 1e Pi	eral Dire	ectic ville	n , Md. 20852	
IMMEDIATE CAUSE (Fir disease or condition resulting in death) Sequentially list condit if any, leading to imme cause. Enter UNDERLY CAUSE (Disease or injuthat initiated events resulting in death) LAS	lons, diete ling c	DUE TO (OR AS A	CONSEQUENCE OF)	:	listase	isla	dese	en	Onsat and Death	
PART II. Other significa							24e. WAS AN AUTO PERFORMED 1 YES 2	2	24b. WERE AUTOPSY FINDINGS MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO	
25. WAS CASE REFERRED T	O MEDICAL H	OSPITAL:	26. PLACE OF DEATH	N (Check only one)						
1 PYES 2 NO 27. MANNER OF DEATH 1 Tetural 5 1 2 Accident	Pending Investigation	26a. DATE OF INJURY (Month, Day, Year)	28b. TIME	OF 28c, INJ	RK?		or (Specify) SCRIBE HOW INJUR	RY OCCURE	D	
a D sut-td-	Could not be determined	28s. PLACE OF INJURY building, etc. (Spec	— At home, tarm, st	reet, factory, offic		26f. LOC City	ATION (Street and A or Town, State)	lumber or Ri	ural Route Number,	
2001		i: To the best of my known							use(s) and manner as stated.	
29b. SIGNATURE AND TITLE	1. Kon	DMFLETED CAUSE OF DE	ATN (ITEM 27) (Type,	Print)	P. LICENSE NU	MBER 30	12/2	News	NED (Month, Day, Year)	
STUBUS TO STUBILLY OF COMMONTH, Day,	1995	HEBISTRAR'S SIGN		9 Key	durn Ci	1.0	o Spr-	Me	20748	

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ID THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

	1 - STATE OF MA	RYLAND / DEPAI CERTIF						IYGIENI REG. NO.	E		
	1. DECEDENT'S NAME (First, Middle, Last)	OLI III	TOATE	. 01	DEA		2. DATE OF	DEATH			3. TIME OF DEATH
	RETTY Jeanne LONG DECE								7 10	YEAR 95	3:04 P M
		L SECURITY NUMBER 5. SEX 8. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIR							19	8. BIRTHP	LACE (State or Foreign
	578-40-4621 1 M 2 M F	66 YRS.	MONTHS	DAYS	HOURS	MIN.	June :		29 1	(Country)	ington, DC
	9a. FACILITY NAME (If not institution, give street and number)		9b. CITY	, TOWN C	R LOCATIO	ON OF DE		, 1		TY OF DE	
E	Prince George's Hospital Co	enter	Che	ever	ly				Pri	nce	George¹s
DIRECTOR	RESIDENCE OF DECEDENT			-					<u> </u>		
H	10s. STATE 10b. COUNTY		ry, town o		ION						10d. INSIDE CITY LIMITS?
ō	Maryland Prince George	s Ri	verda	ale							YES 2 NO
¥.	10e. STREET AND NUMBER				. ZIP CODI				10g. CITIZ	EN OF WH	IAT COUNTRY?
FUNERAL	5301 55th Place				2073	/			U.S	.A.	
E	11. MARITAL STATUS 1 Never Merried 2 Merried FORCES? 1						IC ORIGIN? (S		or No-	14. RACE - Black,	- American Indian, White, atc.
ВУ	3 M Widowed 4 Divorced				2 10 NO					Specify	
	15. DECEDENT'S EDUCATION	16e. DECEDENT'S	I I I I I I	OCUBATIO	201		445 1/11	UD 05 0116		I I O T TO A	White
TE	(Specify only highest grade completed)	(Give kind of	work done	during mo	st of workin	g	160. KII	NU OF BUS	INESS/IND	USTRY	
7	Elamentary/Secondary (0-12) College (1-4 or 5+)	Housewi						wn H	ome		
COMPLETED	17. FATHER'S NAME (First, Middle, Last)	Housewa			18 MOTI	IER'S NAI	ME (First, Midd				
	Ralph Anthony Norcia						ildred		. '		
BE	19a. INFORMANT'S NAME (Type/Print)	19b. MAILIN	G ADDRESS	S (Street a	nd Number	or Rural R	Route Number	City or Town	State Zin	Codel	
2	196. INFORMANT'S NAME (Type/Print) Jeanne Trice 196. MAILING ADDRESS (Street and Number or Rural Route Number of Street and Number or Riverda) Jeanne Trice										
	20e. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION — City of To								City or Tow	n, Stata	
	St Buriel 2 Cremation 3 Removal from State Commettery, crematory or other place Commettery 12/06/95 Washington, DC								DC		
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE	- /	22.	NAME AN	ID ADDRES	SS OF FAC	CILITY				
	De Colingles F. B	0101									, P.A.
	23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardisc or respiratory arrest, Approximate										
	shock, or heart failure. List only one cause on each line.										
	Diset and Death										
	disease or condition resulting in death) . Water tatic (AVL (nom A										
	disease or condition resulting in death) Due to (or As A consequence of): Output Due to (or As A consequence of):										
CERTIFICATION	Sequentially list conditions, DUE TO YOR AS A CONSEQUENCE OF:										
AT	If any, leading to immediate cause. Enter UNDERLYING										
FIG	CAUSE (Disease or injury that initiated events Due TO (DR AS A CONSEQUENCE DF):										
E	resulting in deeth) LAST										
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CAL	PART II. Other significent conditions contributing to d	eath but not resulting	in the ur	nderiying	g ceuse g	given in	Part i. 24	a. WAS AN			WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO
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ä	DID TOBACCO USE CONTRIBUTE TO CAL				UNC	ERTAIN	1 🗆				
PHYSICIAN: MED	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PLACE OF DE	OTHEI								
YSI	1 YES 2 NO 1 Inpettant 2	R/Outpatient 3 DOA	4 🗆 Nur	sing Hom		sidence	8 Other (S				
F	27. MANNER OF DEATH 28a. DATE OF II (Month, Day)		JURY		RK7		28d. DESCR	IBE HOW I	NJURY OCC	CURED	
BY	2 Accident Investigation		М		YES 2	NO					
ED	3 Suicide 6 Could not be building, at the datamined	INJURY — At home, farm. c. (Specify)	street, faci	tory, offic	•		28f. LOCATION OF T	ON (Street a fown, State)	ind Number	or Rural Ro	oute Number,
AP	29s. CERTIFIER (Check only cost)										
COMPLET	2 MEDICAL EXAMINER: On the basis of axe	mination and/or investigat	lon, in my o	opinion, d	leath occur	red at the	time, deta en	d pleca, an	d dua to th	e cause(s)	and menner as stated.
ш	29b. SEMATURE AND TITLE OF CERTIFIER	MO			29c, LICI	ENSE NUM	BER		29d, DATI	SIGNED	Month, Day, Year)
TO B	100				1/3	, 62			> (\lambda	-5-	7)
	30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE		e, Print)	Ar	LIAN	4616	nh	- (A . 6	-	400
	(Lichono) - Fecour	- rub 7)	111	-Alte	- /	1		A -/		J- P

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31. DATE FILED (Month, Day, Year)
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BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

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	1 - STATE REGISTRAR		CERTIFI	CATE OF	DEATH	MENTAL HYGII REG. N					
	1. DECEDENT'S NAME (First, Middle, Last) Louisa	W.	Lampl	iear		2. DATE OF DEATH NOVEMBE	z ^{DAY} 29,	1995	3. TIME OF OEATH 9:26A		
	4. SOCIAL SECURITY NUMBER 218 20 0950	1 M 2 F	97 YRS.	F UNDER 1 YEAR HONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.		898	Country	PLACE (State or Foreign) York		
TOR	9a. FACILITY NAME (If not institution, give str Doctors Communit RESIDENCE OF DECEMENT			вь. сіту, тоwn о Lanha:	R LOCATION OF DE		9c. COUP	ITY OF DE			
DIRECTOR	10a. STATE 10b. COUNTY	: George's	10c. CITY,	TOWN OR LOCAT	ION				10d. INSIDE CITY LIMITS? 1 NO		
ERAL	100. STREET AND NUMBER 12405 Shawmont La		I DOW	10f.	ZIP CODE		10g. CITI	ZEN OF W	HAT COUNTRY?		
BY FUNI	11. MARITAL STATUS 1 Never Married 2 Married 3 Wildowed 4 Divorced	12. WAS OECEDENT EVER II FORCES? 1 \(\subseteq \text{ YES} \) IF YES, GIVE WAR OR D	2 NO	13. WAS DEC	20715 ENGENT OF NISPAN Inclination of Nispan Inclination of Nispan Inclination of Nispan Inclination of Nispan Inclination of Nispan Inclination of Nispan Inclination of Nispan Inclination of Nispan Inclination of Nispan	faxican, Puerto Rican, etc.) Black,			- American Indian, White, etc.		
ETED.	15. DECEOENT'S EDUC. (Specify only highest grade of Elementary/Secondary (0-12)		16e. DECEDENT'S U (Give kind of wo life. Do NOT use	rk done during mos	N at of working	16b. KINO OF BUSINESS/INDUSTRY					
COMPL	17. FATNER'S NAME (First, Middle, Last)		Teacher		16. MOTNER'S NA	P.G. Co. Public School					
i iii	Frederick Wolfang	Nietz									
٤	19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)										
	20a. METHOD OF DISPOSITION 1 IX Burlal 2 Cremation 3 Ramor 4 Donation 6 Other (Specify)	val from State con	PLACE AND DATE OF	DISPOSITION /No	me of	Bowie Ma	OCATION	Mbs or Ton	0715 rn, State		
	Camelon Came										
ERTIFICATION	IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST	\$2750.00 M (492)	CONSEQUENCE OF)	he	202	faile	we		Onset and D		
MEDICAL CE	PART II. Other algorificant conditions	contributing to death b	ut not resulting in	the underlying	cause given in	PERF	AN AUTOPSY ORMED? 2 NO		WERE AUTOPSY FINDI AMAILABLE PRIOR TO COMPLETION OF CAUS OF DEATH?		
AN: N	DID TOBACCO USE CONTR	IBUTE TO CAUSE O	F DEATH YES		UNCERTAIN		_		1 YES 2 NO		
PHYSICIAN:		HOSPITAL:		OTHER:	5 - Residence	8 Other (Specify)					
ву РН	27. MANNER OF DEATH 1 Natural 5 Pending 2 Accident Investigation	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME INJU	TY WOI		28d. DESCRIBE NOV	V INJURY OCC	URED			
	3 Suicide 8 Could not be 4 Homicide detarmined	28s. PLACE OF INJURY building, etc. (Spec	28a. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify)					or Rural Ro	ute Number,		
COMPLETED		IAN: To the best of my know : On the basis of examination							and manner as atete		
TO BE CO	296, SIGNATURE AND TITLE OF CERTIFIER	e (m.)	٠		D 26	H92	29d. DATE	SIGNED (Mogth, Day, Year)		
	30. NAME AND ADDRESS OF PERSON WHO YOU MITCHES	Wille K	d. 150	wine pro-el	2. Jakher	3l 20	7 (+	<i>S</i>			
1 9	31. DATE FILEO (Month, Day, Year)	32. FINGISTRAD'S SIGN	ATURE OF CORPORATION								

Websit Small with Effect 347

	Amended #1, 12 for 1 - STATE REGISTRAR	2/4/95, MRT STATE OF MARYL			y County F HEALTH AND OF DEATH	MENTAL HYGIEN	IE	5 384 36	
100	1. DECEDENT'S NAME (First, Middle, Last)	Mary Hele				2. DATE OF DEATH	MY 1. 199	YEAR 3. TIME OF DEATH	
	4. SOCIAL SECURITY NUMBER 286-20-9865	1 □ M 2 🔯 F	70 YRS.	MONTHS DA	AYS HOURS MIN,	7. DATE OF BIRTH (Month, Day, Year) March 5,	1925	6. BIRTHPLACE (State or Foreign Country) Canada	
TOR	98. FACILITY NAME (If not institution, give a 19 Paca P1 RESIDENCE OF DECEDENT			9b. CITY, TO	Rockvi			Montgomery	
DIRECTOR		tgomery		ry, town or L				10d, INSIDE CITY LIMITS? 1 X YES 2 NO	
FUNERAL	100. STREET AND NUMBER 19 Paca Place				101. ZIP CODE 20852			ted States	
В	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN FORCES? 1 YES	2 NO	If yo	B DECENDENT OF HISPA e, apacify Cuban, Mexic YES 2 1 NO Speci		s or No-	No- 14. RACE - American Indian, Black, White, etc. Specify: White	
COMPLETED	15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12)	JCATION e completed) College (1-4 or 5+)	16a. DECEDENT'S (Give kind of life. Do NOT u	work done during se retired.)	PATION ng most of working	Montg Gover	omery	County	
8	17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S N.	AME (First, Middle, Maiden	Surname)		
BE	(not availab)	le)	Bailey	-		Lamb			
2	Jo Ann Jackson 24601 Frontier Street, Damascus, Maryland 20872								
	20s. METHOD OF DISPOSITION 1								
	21. SIGNATURE OF FUNERAL SERVICE LIG	censee i	M00198	Robe Rock Rock	rt A. Pump ville, Ind ville, Man	ohrey Funer 300 West	al Ho Mont	me/ gomery Avenue	
	23. PART I. Enter the incesses, or complications that caused the desth. Do not enter the mode of dying, such as cardiac or respiratory arreat, shock, or heart failure. List only one cause on each line.								
	iMMEDIATE CAUSE (Final disease or condition resulting in death)	METASTATIC DUE TO (OR AS A	NON-SU CONSEGUENCE O	WL CE	Li GARCII	JOHN OF LE	FT Luy	Oncert and Ocean	
CERTIFICATION	Sequentially list conditions, if sny, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b							
DICAL	PART II. Other aignificent condition	is contributing to death bu	at not resulting	in the under	tying ceuse given in	Part I. 24a. WAS AN PERFO	RMED?	24b. WERE AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?	
PHYSICIAN: MEDICAL	DID TOBACCO USE CONT		F DEATH YE			N 💆		1 □ YES 2 X NO	
Sic	EXAMINER? 1 YES 2 NO	HOSPITAL: 1 Inpetient 2 ER/Outpe	utlant 3 DOA	OTHER: 4 Nursing	Home 5 N Residence	6 Other (Specify)			
ВУ РН	27. MANNER OF DEATH 1 X Natural 5 Pending 2 Accident Investigation	28a. DATE OF INJURY (Month, Day, Year)	28b. TIM	JURY	WORK?	28d. DESCRIBE HOW	NJURY OCCL	PRED	
	3 Suicide 8 Could not be 4 Homicide determined	28e. PLACE OF INJURY building, etc. (Special Control of the Contro	At home, ferm,	street, factory,	office	28f. LOCATION (Street City or Town, State)		r Rural Route Number,	
COMPLETED		ICIAN: To the best of my knowle						i. cause(s) and manner as stated.	
	THE NUMETURE AND TITLE OF CERTIFIE				29c. LICENSE NU			SIGNED (Month, Day, Year)	
TO BE	NAME AND ADDRESS OF PERSON WH	2000 mis	THE STEEL ST. CT.		D 0728	35		cember 1, 1995	

Center Drive #300 Rockville, Maryland 20850

NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

Medical

32. REGISTRAR'S SIGNATURE
Julia Daudler Randak

9707

1995



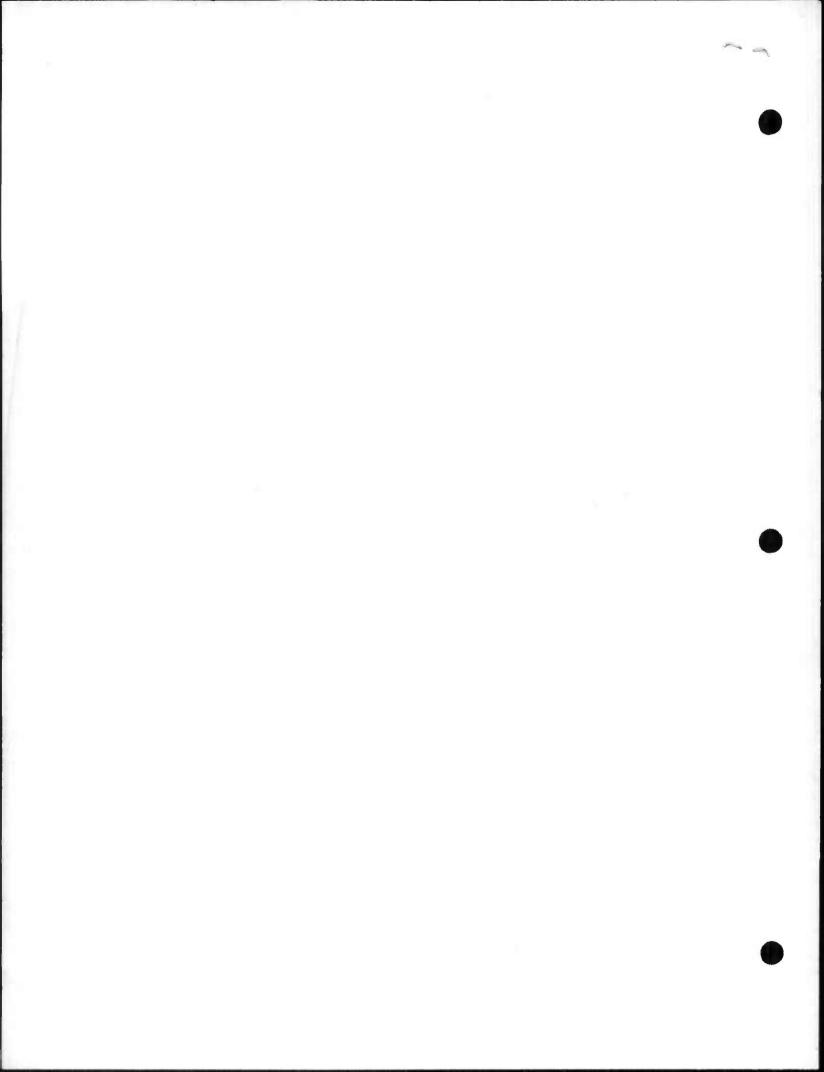
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31. DATE FILED (Month Day.

M.D.

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	FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPART				ILENE . NO.	00401	
	1. DECEDENT'S NAME (First, Middle, Last) CHARLES RICHARD	A seed and	IARD LANDO	N		2. DATE OF DEATMONTH	TH DAY	YEAR 3. TIME OF DEATH	
	4. SOCIAL SECURITY NUMBER 218-05-8975	/		IF UNDER 1 YEAR ONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRT (Month, Day, Ye Oct. 6,	ear)	BIRTHPLACE (State or Foreign Country) Maryland	
DIRECTOR	90. FACILITY NAME (If not institution, give str Edw.W.McCready Mer			Crisfi	eld	EATH	Some	ry of DEATH rset	
D	10a. STATE 10b. COUNTY		10c. CITY,	TOWN OR LOCAT	ION			10d. INSIDE CITY	
	Maryland 10s, STREET AND NUMBER	Somerset		Crisfield			1		
FUNERAL	2964 Ape Hol	e Road		101	21811	7		EN OF WHAT COUNTRY?	
E E	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR D. WORLD WAR I	2 NO	If yes, sp	ENDENT OF HISPAI ecity Cuben, Mexics 2 NO Specif	NIC ORIGIN? (Speci in, Puerto Rican, et y:	fy Yea or No— 1	4. RACE — American Indian, Black, White, atc. Specify: White	
	15. DECEDENT'S EDUC (Specify only highest grade of	ATION completed)	16a. DECEDENT'S US (Give kind of wor	k done during mo	ON st of working	16b. KIND O	F BUSINESS/INDU	STRY	
APLET	Elementary/Secondary (0-12) Grade 6	College (1-4 or 5+)	Ille. Do NOT use :	Driver		Mo	otor Fre	ight	
COMPL	17. FATHER'S NAME (First, Middle, Last)					ME (First, Middle, M	alden Sumame)		
	Charles C. La	ndon				B. Ward			
2	19a. INFORMANT'S NAME (Type/Print) Pansy S. Landon (1	wife)				Crisfie		21817	
	20a. METHOD OF DISPOSITION 1 Burlel 2 Cremation 3 Ramo 4 Donation 5 Other (Specify)	val from State 20b	PLACE AND DATE OF	DISPOSITION (Na r place) METERY	me of 12/6	1 1	c. LOCATION — CI Crisfie		
	21. SIGNATURE OF FUNERAL SERVICE UP			22. NAME AN	shaw & S	ons Fune		e , MD 21817	
	23. PART I. Enter the diseases, or co	omplications that caused	the death. Do not	entar the mo	da of dying, suc	h sa cardiac or	respiratory erre	st, Approximats	
	ahock, or heart failure. L IMMEDIATE CAUSE (Finel disease or condition resulting in death)	GARC	IND M	1A	Lo	NG		Onset and Death	
z	bue to (or all a consequence of):							u se	
HILICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING								
CERTIFI	CAUSE (Disease or injury that initiated events resulting in death) LAST	TO I ON AS A	BETAS	,			9	YY5	
ALC	PART II. Other algnificant conditions	contributing to death b	ut not resulting in	the underlying	ceuse given in		AS AN AUTOPSY	24b. WERE AUTOPSY FINDINGS	
MEDIC							RFORMED?	AVAILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH?	
- 11	DID TOBACCO USE CONTR	IBUTE TO CAUSE O	F DEATH YES	NO [UNCERTAII			1 TYES 2 NO	
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?		26. PLACE OF DEATH	Check only one)					
2	1 TYES 2 W NO 27. MANNER OF DEATH	HOSPITAL: 1 Vinpetient 2 ER/Outp		☐ Nursing Hom		8 Other (Specify)		
- 1	1 Natural 8 Pending Investigation	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME (Y WO	JRY AT RK? ES 2 NO	29d. DESCRIBE H	IOW INJURY OCCU	RED	
ED B	3 Suicide 8 Could not be detarmined	28s. PLACE OF INJURY building, stc. (Spec	— At home, farm, stre	et, factory, office		28f. LOCATION (S City or Town,	treet and Number of State)	Rural Route Number,	
MPLE		IAN: To the best of my knowl							
3	29b. SIGNATURE AND TITLE OF CERTIFIER	On the basis of axamination	and/or investigation,	in my opinion, d	ath occured at the			cause(s) and manner as stated.	
	M. K	5.23 AR	HAN		12-	764	12	13195	
	Dr. M. Barhan, 4				field, Mo	d. 21817		, ,	
	31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNA	ATLIRE						
	DEC 05 1995 Julia	oh winding work	a						

BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within—or hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If them 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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DIVISION OF VITAL RECORDS, P.O. BOX 6876	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in t	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or re-	IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the med
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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR 1 -CERTIFICATE OF DEATH REG NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH NOVEM DET 11:35AM 7. DATE OF BIRTH (Month, Day, Year) 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) BIRTHPLACE (State or Foreign Country) IF UNDER 1 YEAR IF UNDER 24 HRS. 1 M 2 X F 183-14-5038 June 29, 1916 Pennsylvania 9a. FACILITY NAME (If not institution, give street and number, 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH Harford Fallston General Hospital Fallston DIRECTOR RESIDENCE OF DECEDENT 10b. COUNTY 10a. STATE 10c. CITY TOWN OR LOCATION 10d. INSIDE CITY Maryland 1 YES 2 NO Harford Joppa 10s. STREET AND NUMBER FUNERAL 101 ZIR CODE 10g. CITIZEN OF WNAT COUNTRY? 21085 USA 408 Haslett Road 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No—If yes, specify Cuban, Maxican, Puario Rican, atc.)

1 YES 2 NO Specify: 14. RACE — American Indien, Black, White, atc. 1 Never Married 2 Merried Specify: BY 3 Widowed 4 XDivorced White 16a, DECEDENT'S USUAL OCCUPATION ETED 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highe (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) COMPL Executive Secretary Medical Industry 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Meiden Surname) Arnold Wellington Quinney Bertha Inez Sutton 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Flural Route Number, City or Town, State, Zip Code) 2 1567 Brookfield Rd., Newtown, Pa. Geraldine I. Hixson 20g. METHOD OF DISPOSITION 1. Burlal 2 Cremation 3 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State Canaan Corners Cemetery 12-5-95 Waymart, Pa. 4 Donation 5 Other (Specify) ERTURE OF UNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY
HOWARD K. McComas Funeral Home Howard K. McComas Funeral Hom 1317 Cokesbury Rd., Abingdon, ahock, or heart fallure. List only one cause on each line. 1317 Cokesbury Rd., Abingdon, Md. 21009 Interval Between IMMEDIATE CAUSE (Final **Onset and Death** disease or condition_ SHOCIC (EPTIC Juy resulting in death) DUE TO (OR AS A CONSEQUENCE OF) PARUMON14 days CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): If sny, leading to immediate cause. Enter UNDERLYING CHNONIC OBSTRUCTURE CLAVE NIFFERSE CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS MEDICAL PERFORMED? AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 TYES 2 KNO 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: 28. PLACE OF DEATH (Check only one) 25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL: OTHER:
4 | Nursing Home 5 | Residence 8 | Other (Specify) I Ninpatient 2 ER/Outpatient 3 DOA 28a. DATE DF INJURY (Month, Day, Year) 28b, TIME OF INJURY 27. MANNER OF DEATH 28c. INJURY AT WORK?
1 YES 2 ND 28d. DESCRIBE HOW INJURY OCCURED 5 Pending Investigation 1 Natural BY 2 Accident 28a. PLACE OF INJURY — At home, term, street, fectory, office building, etc. (Specify) 3 Suicide 281. LOCATION (Street end Number or Rural Route Number, City or Town, State) ETED 8 Could not be 4 Homicide 29a. CERTIFIER
(Chack aniv The Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(e) and manner as stated. COMPL (Check only one) 12 - MEDICAL EXAMINER: Do the basis of examination end/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(e) and menner es stated. 29b. SIGNATURE AND TITLE DE CE 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) 1035843 December 11895 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) NOCK PHILLIPS 2005 SPRING mi FORRIT HILL 2/050 RD 31. DATE FILED (MORITE DE) 32. REGISTRAR'S SIGNATURE
FILLS DRUMEION ROYALL

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within the flow in the death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If them 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	FOR 1 - STATE REGISTRAR	STATE OF MARY	'LAND / DEPAR' CERTIFI	TMENT OF	HEALTH AND	MENTAL	HYGIEN REG. NO.	E		0010	
	1. DECEDENT'S NAME (First, Middle, La	'S NAME (First, Middle, Last)					OF DEATN			3. TIME OF DEA	TN
	Lillian	H. Lauren	t			NOVE	ember "		995	7:20	Рм
	4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE (In vrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 MBS 7 DAT					OF BURTH	JU/ 1	BIRTHE	PLACE (State or F	
	501-09-3076 9a. FACILITY NAME (If not institution, given		90 YRS.	MONTHS DAYS	HOURS MIN.	Apri	L1 5,			h Dakot	a
œ			1		OR LOCATION OF DEATH					ATH	
DIRECTOR	Howard County G	eneral Hospi	cal.	Colum	lb1a			How	ard		
Ä	10a. STATE 10b. COU	NTY	10c. CITY	, TOWN OR LOCA	TION					10d. INSIDE CIT	Υ
	Maryland Ho	ward	El	licott.	City					1 YES 2	(NO
¥	10e. STREET AND NUMBER			10	1. ZIP CODE			10g. CITIZ	EN OF W	HAT COUNTRY?	
FUNERAL	9934 Frederick				21042			Unit	ed S	tates	
2	11. MARITAL STATUS 1 Never Married 2 Married	12. WAS DECEDENT EVER		13. WAS DE	CENDENT OF HISPAI	NIC ORIGIN	? (Specify Yes	or No-	14. RACE Black.	- American Ind White, atc.	len,
BY	3 🔀 Widowed 4 🗌 Divorced	IF YES, GIVE WAR OF	DATES		NO Specif		,		Spec/fy		
	15. DECEDENT'S E	DUCATION	16a. DECEDENT'S	USUAL OCCUPATI	ON	16b	KIND OF BUS	INESS/INDI	ISTRY	White	
	(Specify only highest gr Elementary/Secondary (0-12)	College (1-4 or 5+)		rork done durina m		1.00.	Table of Boo	iii Caariii o	991111		
COMPLETED	12		Furnitu	re Buye	r		Retai	1			
Į	17. FATHER'S NAME (First, Middle, Last)				18. MOTNER'S NA	ME (First, N	fiddle, Maiden	Sumame)			
BE	John J. Schmi	dt			Elizab	eth	Reisw	ig			
0	19a, INFORMANT'S NAME (Type/Print)		19b. MAILING	ADDRESS (Street	and Number or Rural	Route Numb	er, City or Town	, State, Zip	Code)		
-	Mrs. Patricia W	eyhrauch	9934	Frederi	ck Road	Elli	.cott (City,	MD	21042	
ı	20a. METHOD OF DISPOSITION 1 ☐ Burial ZZZ Cremation 3 ☐ R	emoval from State	emetery, cremetory or of	F DISPOSITION (N	ame of	DATE	20c. LO	CATION — C	Ity or Tow	rn, State	
	4 Donation 5 Other (Specify)		emetery, cremetory or of Balt-Washi	ngton C	rematory	12-4	Lau	rel,	Mar	yland	
i	Harry H. Witzke Funeral Home, Inc.							c.			
	Show a.	Collins			Old Colu						.043
NO	23. PART I. Entar the diseases, properties of the second shock	a. Sepsis Due to (or A:	s a consequence of 7 Tract In	: fection	da oi dying, auc	en aa caro	ac or respi	ratory arre	eat,	Approximintarval B Onset and 1 day	latween d Daath
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):										
PHYSICIAN: MEDICAL	PART II. Other algoriticant condition Congestive Heating Hypertension		but not resulting in	n tha undarlyin	g cause given in	Part I.	24a. WAS AN PERFOR	MED?		WERE AUTOPSY F AVAILABLE PRIOR COMPLETION OF OF DEATH?	TO
Σ	DID TOBACCO USE CON	ITDIDLITE TO CALLEE	OF DEATH VE	CVI NO F	1 UNICEDIAN					1 YES 2	NO
Y	25. WAS CASE REFERRED TO MEDICAL		26. PLACE OF DEAT		UNCERIAL	<u> </u>					
2	EXAMINER? 1 YES 2 NO	HOSPITAL:		OTHER:	ne 5 🗆 Residence	a - Oth	(0//-)				
Ë	27. MANNER OF DEATN	28a. DATE OF INJUR	Y 28b. TIME	OF 28c. IN.	IURY AT	_	CRIBE HOW IN	JURY OCC	URED		-
1 P	1 Netural 5 Pending 2 Accident Investigatio	(Month, Day, Year) INJ(JRY WO	YES 2 NO						
100	2 Accident Investigatio 3 Suicide 8 Could not to	28a. PLACE OF INJU	RY — At home, farm, at	Ireat, factory, offic			ATION (Street a	nd Number o	or Rural Ro	oute Number,	$\neg \neg$
COMPLETED	(Check only 1 & CERTIFYING PN	YSICIAN: To the best of my known with the second sec								and manner as a	risted.
	29b. SIGNATURE AND TITLE OF CERTIF		70.0		29c. LICENSE NUI	MBER		29d. DATE	SIGNED (Month, Day, Year)	
	Margaret K	Horohoe			D43345			Nov	v. 30	0, 1995	
2 ∦	30. NAME AND ADDRESS OF PERSON	WNO COMPLETED CAUSE OF	DEATN (ITEM 27) (Type,	Print)						,	
	Margaret R. Doi		01 Old An	napolis	Road #20	00 El	licott	City	y, M	21042	
	DEC 0 7 1995	22. REGISTRAR'S SIG	SNATURE								
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TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending phys	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the buri	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to bunal, cremation, or removal.	IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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	FOR STATE REGISTRAR		STATE OF M	ARYLAND /	DEPAR	ITMEN'	T OF H	EALTH DEAT	AND N	MENTAL	HYGIEN REG. NO)	001	140
	t. DECEDENT'S NAME (First, Min	iddle, Last)								2. DATE (OF DEATH		YEAR	3. TIME OF	DEATH
	WILLIAM	Т.	MOR'	ION Sr	^						EMRER		1004	0.	56P *
- 1	4. SOCIAL SECURITY NUMBER			8. AGE (In yrs. les			I 1 YEAR	IF UNDER 2		7. DATE C		207		PLACE (State	or Foreign
3	578-52-7543		1X M 2 F	53	YRS.	MONTHS	DAYS	HOURS	MIN.			1942			on, D.
	9a. FACILITY NAME (If not institu	ution, give stre	iet and number)			9b. CITY	Y, TOWN C	R LOCATIO				9c. COL	INTY OF D	EATH	<i>7.11 D</i> • ·
5	Prince Georg	es Hos	spital C	enter			(Cheve	rly			Pri	nce (George	e's
5	RESIDENCE OF DECEL	DENT			T.,										
DIRECTOR				l w	10c. CI1	Y, TOWN			3 -					10d. INSIDI	3?
	Maryland 100. STREET AND NUMBER	PLINCE	e George	S		Lanc		ZIP CODE	ııs					t 🔯 YES	
FUNERAL							101		704					VHAT COUNT	
y l	7004 Barton R		12. WAS DECEDENT			1			784					State	
	1 Never Married 2 Ma		FDRCES? 1	YES 2			If yes, sp	cify Cuben	, Mexican	, Puarto R	? (Specify Yes ican, etc.)	or No—		E — America k, White, atc.	n Indian,
BY	3 Widowed 4 Divorce		12-7-62		-64		t [] YES	2 XND	Specify:				Speci	Black	
3		ENT'S EDUCA	ATION	18a. DI	ECEDENT'S					16b.	KIND OF BU	SINESS/IN	DUSTRY		_
<u>.</u>	(Specify only high Elementary/Secondary (0-12)		ompleted) Callege (1-4 or 5+)	like	give kind of a. Do NOT u	work done se retired.)	during mo	st of working	7						
COMPLETED	12	·			True	ck Di	rive	_			Gover	nmen	t		
5	t7. FATHER'S NAME (First, Middle	lle, Last)	<u> </u>					18. MOTH	ER'S NAM	ME (First, M	liddle, Maiden	Sumame)			
BEC	Leodies Ho	pkins						Ire	ne N	Naylo	r				
	19a. INFORMANT'S NAME (Type	/Print)		19	b, MAILING	ADDRES	S (Street a				er, City or Tow	n, State, Z	ip Code)		
2	Mildred L. M	orton			7004	Bart	ton 1	Road,	Lan	ndove	r Hil	ls, I	Mary]	Land	20784
	20s. METHOD OF DISPOSITION 1 № Burlal 2 □ Cremation		ml from Chat-	20b. PLACE				me ol		DATE	20c. LO	CATION -	- City or To	wn, Stata	
	4 Donation 5 Other (Sp		TELL TOWN STATE	Maryl	and V	Vete:	rans	Ceme	tery	12/	7/95	Che.	ltenh	nam, N	1D
ı	21. SIGNATURE OF PHINERAL B	SERVICE LICE	NSEE			22.	NAME AP	ART F	S OF FAC	YILITY					
- 1	1 Lolen	1 8	num of	111								TaT	ahine	rton	DC
-	23. WHIT I. Enter the dise	BBAB OF CO	mplicetions that	caused the di	neth Do						, N.E				roximata
	ahock, or heer IMMEDIATE CAUSE (Final disease or condition_	rt fellure. Li	GASTE	ne on each line	e.								rout,	Inter Onse	val Between the and Death
H	resulting in desth)		DUE TO (DR AS A CONSE	DUENCE D	E:								-	T / IOUI,
z			ALCOHO	DUC LI	VER	D	ISE,	ASE.	- CI	RRH	2120			Y	2 aus
EHITICATION	Sequentially list condition if any, leading to immedia	10,	DUE TO (DR AS A CONSE	DUENCE D	F):									
5	cause. Enter UNDERLYING CAUSE (Disesse or Injury	G C.	ALCOH				201	1C						y,	zours
=	that initiated events resulting in death) LAST		DUE TO (DR AS A CONSE	OUENCE C	IF):									
H.	resulting in destil) CAST	d.													
2	PART II. Other significent	conditions	contributing to	deeth but not	resulting	In the u	nderlyln	ceuse g	lven in i	Part I.	24a. WAS AN		24b		PSY FINDINGS
MEDICAL											PERFOI	-			N DF CAUSE
급										_ [I U TES	CONO		OF DEATH?	
2	DID TOBACCO USE	E CONTR	IBUTE TO CA	USE OF DEA	ATH Y	ES 🖂	NO F	UNC	ERTAIN	IM				1 1 463	2 NO
A P	25. WAS CASE REFERRED TO N				CE DF DE				-1(1					
2	EXAMINER?		HOSPITAL:	ER/Outpatient	3 DOA	OTHE		e 5 □ Ras	aldence	f C Other	(Specify)				
PHYSICIAN:	27. MANNER DF DEATH		28a. DATE OF	INJURY	28b. TII	AE OF	28c. INJ	URY AT	- I		CRIBE HOW	INJURY O	CCURED		
-	1 Natural 5 Per	nding restigation	(Month, Da	ly, Year)	IN	JURY M		RK? (ES 2 _	NO						
ן מ	2 Suitstde	S-12115A	28e. PLACE DI	FINJURY — At h	ome, farm,	atreet, fac	ctory, offic			28f. LOCA	ATION (Street	and Numbi	er or Runsi I	Route Numbe	ς.
		uid not be termined	building,	etc. (Specify)						City o	or Town, State,)			
Ц	29a. CERTIFIER	VINC BUVE'S	IAM. To the best of	many has any to store	and by the second			- 4.1							
COMPLETED	(Check only		IAN: To the best of ax											a) and mar	as an aleted
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E E	296. BIGHANUTE AND TITLE OF) / A	TAL	MA	X			29c. LICE	NSE NUN	IO O	0	29d. DA	TE SIGNED	(Month, Day	Ybar)
2	30, NAME AND ADDRESS/OF P	CDC VI	COMBLETE		_	0		1	151	00	7	L	ecem	per I, I'	442
- 1	30. NAME AND ADDRESS OF P	CHW NUCKE	CUMPLETED CAUS	IN OF DEATH //TE	EM 27) /7vo	n Print									

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE DF DEATH (ITEM 27) (Typo, Print)

MORRIS JUTCOVICH, 8201 Corporate Drive Swik620

31. DATE FILED (Month, Day, Year)

DEC 5 1995

32. SEGISTRAP'S SIGNATURO Landover, MD2078

and the rest of the second second second second second second second second second second second second second

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 s filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. PORTANT: If Nem 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	1 - FOR STATE REGISTRAR	TE OF MARYLAN	D / DEPARTM			MENTAL HYGIEN		
3	t. DECEDENT'S NAME (First, Middle, Lest) MATTIE M. MILLE	R	OLIVII 107	114 01		2. DATE OF DEATH MONTH	-	3. TIME OF DEATH 95 3:15 P. M
	4. SOCIAL SECURITY NUMBER 243-42-0996 5. SEX 1	2X F 64	YRS. MON		IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Ybar) August 3,	0.	BIRTHPLACE (State or Foreign Country) Monroe N.C
OB	Holy Cross Hospita		96.		er Sprin		Jomery	
AAL DIRECTOR	PRESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY District of Columbia 10e. STREET AND NUMBER	Washington 10c. CITY, TOWN OR LOCATION 101. ZIP CODE					tod. INSIDE CITY LIMITS? 1 ★ YES 2 NO IZEN OF WHAT COUNTRY?	
BY FUNERAL		S. ARMED	ED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Spe				ed States RACE — American Indian, Black, Whita, atc. Specify: Black	
COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade complete Elementary/Secondary (0-12) Colleg	18 • (1-4 or 5 +) 4	a. DECEDENT'S USU (Give kind of work life. Do NOT use rec School	done during mos	st of working	Washing Board	gton, D). C.
BE COM	17. FATHER'S NAME (First, Middle, Last) John McCullough	18. MOTHER'S NAI Mar	ME (First, Middle, Maider y Horne					
10	19e. INFORMANT'S NAME (Type/Print) Marie Jordan					Temple H		
	2 Surial 2 Cremetion 3 Removal from 4 Donation 6 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 23. PART I. Enter the diseases, or compiled	TII stions that caused the		orial STEWA 4001	RE FUNER Benning	Road, N.E	.,Wash:	
7	ahock, pr heart failure. List on IMMEDIATE CAUSE (Final disease or condition resulting in death)	STRO DUE TO (OR AS A CO	teo					Interval Between Onset and Death 3 well fes.
CERTIFICATION	Sequentisity list conditions, if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST	DUE TO (OR AS A CO						
AL	PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PROPRIED? AMILABLE PRIOR TO							COMPLETION OF CAUSE OF DEATH?
BY PHYSICIAN: MEDIC	TES Z NO	26. PITAL: patient 2 ER/Outpette ie. DATE OF INJURY (Month, Day, Year)		F 28c. INJ		5 Other (Specify) 28d. DESCRIBE HOW	INJURY OCCUP	RED
ED		a. PLACE OF INJURY — building, atc. (Specify)	At home, farm, stree	of, factory, offic	•	281. LOCATION (Street City or Town, State		Rural Route Number,
COMPLET	29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the							Section of the second
TO BE 0	29b. SIGNATURE AND TITLE OF CENTIFIER 30. NAME AND ADDRESS OF PERSON WHO COMP	llaw	WYS	ngh.	D 4 7	-518	29d. DATE S	HOND 29, 1995 ON 29, 1995 FOULLOT PID 200
_	Bu CHAISCONI	, 1111		chevi	us of	100 # 316	Roc	terrico MDZas
	DEC 4 1995	EGISTRAR'S SIGNATI	Robert					

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BALTIMORE, MARYLAND 21215-0020

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DIVISION OF VITAL RECORDS, P.O. BOX 68/60	ortal on ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours
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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 is be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND / DEPARTMENT	OF HEALTH AND MENTAL	HYGIENE
CERTIFICATE	OF DEATH	REG. NO.

1. DECEDENT'S NAME (First, Middle, Lest)		CERTIFIC	CATE OF	DEATH	MENTAL	REG. NO.				
					2. DATE (OF DEATH		EAR 3	. TIME OF DEATH	
Lucienne	P. Meacher	n			Nov.	28,	1995		1:00 A.M.	
4. SOCIAL SECURITY NUMBER			F UNDER 1 YEAR	IF UNDER 24 HRS.		Day, Year)		BIRTHPL Country)	ACE (State or Foreign	
130 10 2137	1 M 2 X 75				Dec. 12,1919 New York					
9a. FACILITY NAME (If not institution, give st Crofton Convales			ob. City, town of	OR LOCATION OF DE	EATN				inde1	
RESIDENCE OF DECEDENT										
10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION								1	6d. INSIDE CITY LIMITS?	
Maryland Anne	aryland Anne Arundel Crofton								TES XX NO	
10e. STREET AND NUMBER								N OF WH	OF WHAT COUNTRY?	
1662 Carlyle Dri								United Stat		
11. MARITAL STATUS	TORONO A THE ATTEND						or No- 14	No- 14. RACE — American Indian, Black, White, etc.		
1 Never Married 2 Merried 3 Wildowed 4 Divorced	IF YES, GIVE WAR OR D		1 TYES	No	Specify: White					
15, DECEDENT'S EDU	ICATION	16a. DECEDENT'S U	SUAL OCCUPATION	ON		KIND OF BUS	NESS/INDUS	TRY	WILLE	
(Specify only highest grade Elementary/Secondary (0-12)			irk done during mo							
12	College (1-4 or 5+)	Secretar	су			Ban	king			
17. FATHER'S NAME (First, Middle, Last)				10. MOTHER'S NA	ME (First, N	liddle, Maiden S	Surname)			
Adrian Pierrard				Gertru	ude	Dore'				
19a. INFORMANT'S NAME (Type/Print)		19b. MAILING	ODRESS (Street	and Number or Rural	Route Numb	er, City or Town	, State, Zip C	ode)		
Robert E. Meachem	n	1662	Carly1	Drive	Crof	ton Ma	rylan	d	21114	
20s. METHOD OF DISPOSITION 1X∑Buriel 2 ☐ Cremation 3 ☐ Rem	noval from State Ca	b. PLACE AND DATE OF	FDISPOSITION (Na	ame of	DATE		ATION - CH			
4 Donation 5 Other (Specify)		dary Land				/1/95	Crown	svil	le Md.	
21, SIGNATURE OF FUNERAL SERVICE LIC	CENSEE	D		nd address of fa rt E. Ev		uneral	Home	. P	. A .	
* Koweit C.	. CUDIVIS	Mes		O Annapo						
23. PART I. Enter the diseases, or shook or heart fellure	complications that cause List only one cause on a								Approximate Interval Between	
IMMEDIATE CAUSE (Finel	HI M ARET	aacri iine.	0	1 -					Onset and Das	
disease or condition 101 with Inbart Dengin 1a										
resulting in death)	8.	1 1	No co	inlia						
resulting in death)	DUE TO (OR AS	A CONSEQUENCE OF	- Q	ulla -						
	HIS LOVE TO (OR AS	a consequence of	t Dry	fection						
Sequentially list conditions, if any, leading to immediata	DUE TO (OR AS	A CONSEQUENCE OF	t Dry	feelwr						
Sequentisily list conditions, if any, leading to immediata cause. Enter UNDERLYING CAUSE (Disease or injury	DUE TO (OR AS	A CONSEQUENCE OF	:	fection						
Sequentially list conditions, if any, leading to immediata cause. Enter UNDERLYING	DUE TO (OR AS	A CONSÉQUENCE OF	:	fection						
Sequentially list conditions, if any, leading to immediata cause. Enter UNDERLYING CAUSE (Disease or injury that initieted events resulting in death) LAST	c. DUE TO (OR AS d.	A CONSEQUENCE OF	:	J						
Sequentially list conditions, if any, leading to immediata cause. Enter UNDERLYING CAUSE (Disease or injury that initieted events	c. DUE TO (OR AS d.	A CONSEQUENCE OF	:	J		24a. WAS AN PERFORI		1	WAILABLE PRIOR TO	
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Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initieted events resulting in death) LAST PART II. Other significant condition	DUE TO (OR AS d	A CONSEQUENCE OF	:	g cause given in	Part I.	PERFOR	MED?		MAILABLE PRIOR TO COMPLETION OF CAUSE	
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Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significant condition DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL EXAMINER?	DUE TO (OR AS d	A CONSEQUENCE OF A CONSEQUENCE OF but not resulting in OF DEATH YE: 20. PLACE OF DEATH	the underlying NO NO NO NO NO NO NO NO NO NO NO NO NO	g cause given in	Part I.	PERFOR	MED?		MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?	
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Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initieted events resulting in death) LAST PART II. Other significant condition DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1	DUE TO (OR AS C. DUE TO (OR AS d. INSCONTIBUTING TO CAUSE (HOSPITAL: 1 Inpettent 2 ER/Out 28a. DATE OF INJURY (Month, Day, Year) 25a. PLACE OF INJURY building, stc. (Sp.	A CONSEQUENCE OF) A CONSEQUENCE OF) but not resulting in OF DEATH YE: 28. PLACE OF DEATH tepetient 3 DOA 28b. Time inju. Y. — At home, farm, st wiedge, death occurre-	The underlying the un	UNCERTAL DIVIDENTAL DIVIDENT AT DIVIDENT	6 Other 28d, DES 28f. LOC City	PERFORI 1 YES 2 T (Specify) CRIBE NOW IP ATION (Street a or Town, State)	AJURY OCCU	RED Rural Ro cause(a)	MALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? I YES 2 NO Ule Number, and manner as stated.	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initieted events resulting in death) LAST PART II. Other significant condition DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 Jug 27. MANNER OF DEATN 1 Maturel 5 Pending Investigation 3 Suicide 8 Could not be determined 29e. CERTIFIER (Check only one) 2 MEDICAL EXAMIN. 29b. SIGNATURE AND TITLE OF CERTIFIER	DUE TO (OR AS C. DUE TO (OR AS d	A CONSEQUENCE OF) A CONSEQUENCE OF) but not resulting in DF DEATH YE: 20. PLACE OF DEATI telephent 3 DOA 28b. Time injuly — At home, farm, stecify) wiedge, death occurred on and/or investigation	The underlying the un	UNCERTAL DIVINO TO THE TOTAL	6 Other 28d, DES 28f. LOC City	PERFORI 1 YES 2 T (Specify) CRIBE NOW IP ATION (Street a or Town, State)	AJURY OCCU and Number of the state of due to the	RED Rural Ro cause(a) Signed (c	MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? I YES 2 NO ule Number, and manner as stated. Month, Day, Year)	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significant condition DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 YES 27. MANNER OF DEATN 1 Naturel 5 Pending investigation 3 Suicide S Could not be determined 29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINER 29b. SIGNATURE AND TITLE OF CERTIFIER (Check only one) 1 CERTIFIER (Check only one) 1 MEDICAL EXAMINI 29b. SIGNATURE AND TITLE OF CERTIFIER	DUE TO (OR AS C. DUE TO (OR AS d	A CONSEQUENCE OF) A CONSEQUENCE OF) but not resulting in DF DEATH YES 20. PLACE OF DEATH 128b. TIME 17.—At home, farm, st ecity) wiedge, death occurre- fon and/or investigation	NO NO NO NO NO NO NO NO NO NO NO NO NO N	UNCERTAL DIVIDENTAL DIVIDENT AT DIVIDENT	6 Other 28d, DES 28f. LOC City	PERFORI 1 YES 2 T (Specify) CRIBE NOW IP ATION (Street a or Town, State)	AJURY OCCU and Number of the state of due to the	RED Rural Ro cause(a) Signed (c	MALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? I YES 2 NO Ule Number, and manner as stated.	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initieted events resulting in death) LAST PART II. Other significant condition DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 Jug 27. MANNER OF DEATN 1 Maturel 5 Pending Investigation 3 Suicide 8 Could not be determined 29e. CERTIFIER (Check only one) 2 MEDICAL EXAMIN. 29b. SIGNATURE AND TITLE OF CERTIFIER	DUE TO (OR AS DUE TO (OR AS DUE TO (OR AS DUE TO (OR AS DUE TO (OR AS DUE TO (OR AS DUE TO (OR AS DUE TO (OR AS DUE TO (OR AS DIE OF (OR AS DATE OF INJURY (Month, Dey, Year) 25e. PLACE OF INJURY (Month, Dey, Year) 25e. PLACE OF INJURY (Month, Dey, Year) DUE TO (OR AS DUE TO (O	A CONSEQUENCE OF) A CONSEQUENCE OF) but not resulting in DF DEATH YES 20. PLACE OF DEATH 128b. TIME 177 — At home, farm, st ecity) wiedge, death occurre- fon and/or investigation 1. D. EATH (ITEM 27) (Type.	The underlying No. (Check only one, OTHER ATTURING HOT OF 28c. IN WY 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	UNCERTAL DIVIDENTAL DIVIDENT AT DIVIDENT	6 Other 26d, DES 28f, LOC City to the caue time, date	PERFORI 1 YES 2 T (Specify) CRIBE NOW IP ATION (Street a or Town, State)	AJURY OCCU and Number of the state of due to the	RED Rural Ro cause(a) Signed (c	MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? I YES 2 NO ulle Number, and manner as stated, Month, Day, Year)	

34. . . .

and the second of the

8. BIRTHPLACE (State or Foreign Country)

Maryland

YEAR

95

9c. COUNTY OF DEATH

Montgomery

10g. CITIZEN OF WHAT COUNTRY?

United States

14. RACE — American Indian, Black, White, etc.

3. TIME OF DEATH

10d. INSIDE CITY

1 - YES 2 NO

white

Approximate Interval Between

Onset and Death

day

24b. WERE AUTOPSY FINDINGS

AVAILABLE PRIOR TO

1 YES 2 NO

29d. DATE SIGNED (Month, Day, Year)

195

20814

12/4

COMPLETION OF CAUSE

647 p m

REG. NO

2. DATE OF DEATH

Dec

FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

Florence

funeral director, filled in by the completely executed and physician ; requires that the death certificate be OR ATTENDING PHYSICIAN: The law

4. SOCIAL SECURITY NUMBER 6. AGE (in vrs. leat birthdev) 7. DATE OF BIRTH 5. SEX IF UNDER 1 YEAR | IF UNDER 24 HRS. DAYS HOURS 1 - M 2 - F 579-44-1081A 99 VRS May 18, 1896 permit. Pages 1, 2, 3 should 9a. FACILITY NAME (if not institution, give street and number) 96 CITY, TOWN OR LOCATION OF DEATH DIRECTOR Suburban Hospital Bethesda RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY IDE CITY TOWN OR LOCATION Bethesda Maryland Montgomery 10e. STREET AND NUMBER FUNERAL 101, ZIP CODE burial-transit 8004 Hampden Lane 20814 hours after death. Page 6 may be retained by the hospital or attending physician. 11 MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-If yes, specify Cuban, Maxican, Puerto Rican, etc.) 1 Never Married 2 Married 1 YES 2 NO Specify: BY 3 Widowed 4 Divorced as the ETED 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use relired.) 15. DECEDENT'S EDUCATION ecity only highest grade comple 16b. KIND OF BUSINESS/INDUSTRY 950 (Spe Elementary/Secondary (0-12) College (1-4 or 5+) page 5 should be detached for COMPL Professor 5+ University once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) notified at Frank G. Mears Flora Kate Waidlich 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Kathryn M. Hildebrand 1640 Aberdeen Road, Baltimore, Maryland 21286 must be 20b. PLACEANDDATEOF DISPOSITION (Name of cometery, cremetary or other place) December 6, 1993 Montgomery Crematorium, Inc. 20s. METHOD OF DISPOSITION 20c. LOCATION - City or Town, State 1995 Buriel 2 X Cremetion 3 A 4 Donation 6 Other (Specify) Bethesda, Maryland examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Ave., Bethesda, MD 20814-3501 M00198 an toer medical 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiec or respiratory errest, shock, or heart feiture. List only one cause on each line. 8 IMMEDIATE CAUSE (Final the стетавол. disease or condition DUE TO (OR AS A CONSEQUENCE OF): resulting in deeth) event. DUE TO (OR AS A CONSEQUENCE OF): heart desease burial, other traumatic CERTIFICATION Sequentially liet conditions, 9 If any, leading to immediate cause. Enter UNDERLYING the attending physician Mental Hygiene prior DUE TO (OR AS & CONSEQUENCE OF): CAUSE (Disease or Injury that initiated evente resulting in death) LAST 80id 0 injury, PART II. Other algorificant conditions contributing to death but not resulting in the underlying ceuse given in Part i. 24s. WAS AN AUTOPSY PERFORMED? MEDICAL 200 any Health a 1 YES 2X NO Shows been s DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \(\Boxed{1}\) NO \(\Boxed{1}\) UNCERTAIN \(\Boxed{1}\) PHYSICIAN: Dept. 23 28. PLACE OF DEATH (Check only one) 25. WAS CASE REFERRED TO MEDICAL item certificate to the State er this cer.
*h with the Star. HOSPITAL:
1X Inpetient 2 - ER/Outpetient 3 - DOA OTHER: 1 YES 2 X NO 4 Nursing Home 5 Residence 8 Other (Specify) 28c, INJURY AT WORK? 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 28d. DESCRIBE HOW INJURY OCCURED marked, 1 🙀 Natural 5 Pending 1 YES 2 NO BY After t death 2 Accident 26s. PLACE OF INJURY — At home, farm, streat, factory, office building, atc. (Specify) 281, LOCATION (Street and Number or Rural Route Number, 3 Suicide DIRECTOR: A hours after di 99 COMPLETED 4 Homicide 28 Hell 29a. CERTIFIER (Check only 1 🔀 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) end manner as stated. HOSPITAL FUNERAL within 72 h TO THE HOSPITA
TO THE FUNERAL
DE filed within 72
IMPORTANT: II 2 MEDICAL EXAMINER: On the basis of exemination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(s) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER BE 2317 2 PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

M.

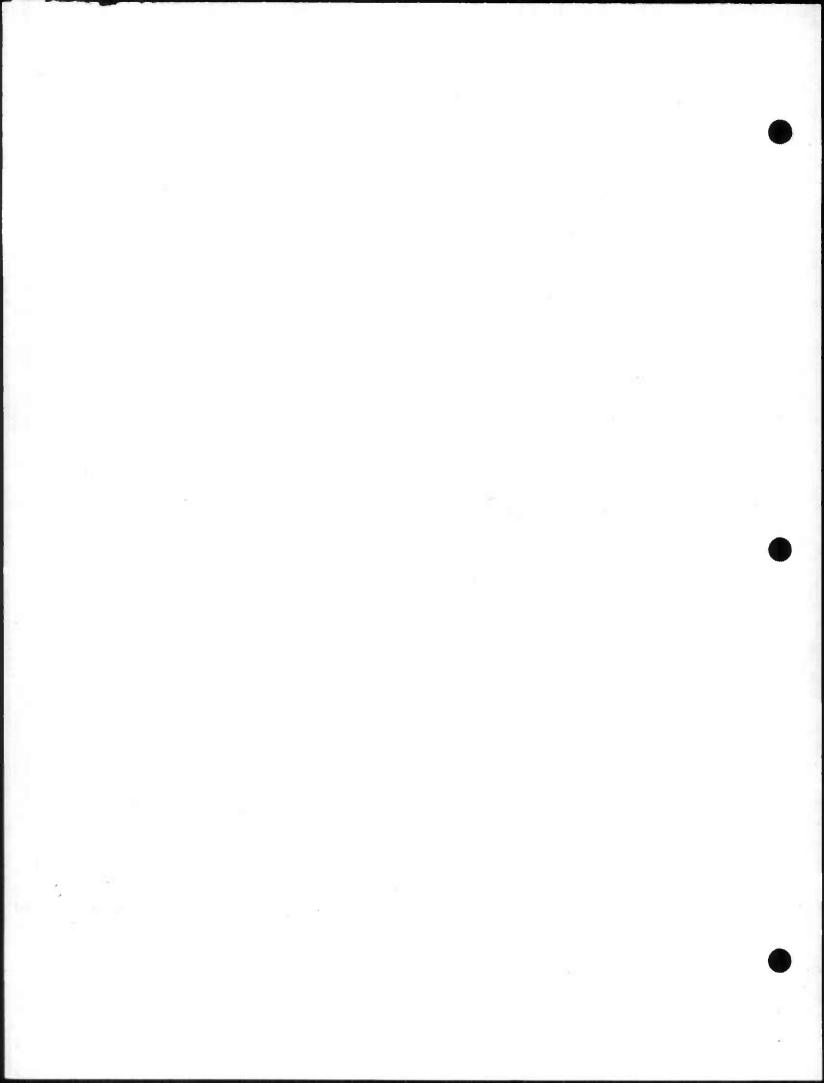
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

Mears

32. REGISTRAR'S ŞIGNATURE 31. DATE FILED (Month, Day, Year) DEC 08 1995 The Dhudson Redall

9406 Old Georgetown Road, Bethesda, Maryland

Gita C. Bakshi, M.D.



YEAR

Korea

22306

1995

14

3. TIME OF DEATH

10:30

10d. INSIDE CITY LIMITS? 1 YES 2 NO

Approximate Intervel Batween

Onset and Death

WERE AUTOPSY FINDINGS

COMPLETION OF CAUSE.

AVAILABLE PRIOR TO

OF DEATH? 1 YES 2 ND

MATTE

e. BIRTHPLACE (State or Foreign 4 Korea

14. RACE — American Indian, Black, White, etc.

Specify Korean

REG. NO.

2. DATE OF DEATH

December

1. DECEDENT'S NAME (First, Middle, Last)

Min

DEC 07 1995

5 SEX

Woon Hee

4. SOCIAL SECURITY NUMBER

7. DATE OF BIRTH AUGUST 14, DAYS HOURS 19 449-35-5107 MIN 81 1 M 2 X F permit. Pages 1, 2, 3 should 9e. FACILITY NAME (If not institution, give street and number, 9b. CITY. TOWN DR LOCATION OF DEATH 9c. COUNTY OF DEATH Shady Grove Nursing and Rehab Center Rockville, MD Montgomery DIRECTOR RESIDENCE OF DECEDENT 10c. CITY, TOWN DR LOCATION Montgomery Maryland Rockville FUNERAL 10e. STREET AND NUMBER 101, ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 20878 14101 Stonecutter Drive use as the burial-transit 12. WAS OECEDENT EVER IN U.S. ARMED 24 hours after death. Page 6 may be retained by the hospital or attending physician. 11. MARITAL STATUS 13. WAS DECENDENT DF NISPANIC DRIGIN? (Specify Yes or No-If yes, specify Cuben, Mexican, Puerto Ri
1 YES 2 NO Specify: FORCES? 1 YES 2 IF YES, GIVE WAR OR DATES 1 Never Married 2 Married BY 3 Widowed 4 Divorced ETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade comp ive kind of work done Do NOT use retired.) funeral director, page 5 should be detached for Elementary/Secondary (0-12) College (1-4 or 5 +) 9 COMPL Housewife Home once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First Middle Maiden Surname) Unobtainable Unobtainable notified at 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Boute Number City or Town, State, Zin Code 2 6715 Beddoo Street, Alexandria, VA Pyong Yol Min 9 20s. METNOD OF DISPOSITION
1 N Burlel 2 Cremetion 3 Removal from State
4 Donetion 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State DATE must National Memorial Park 12-10 Falls Church, VA examiner 21. SIGNATURE OF FUNERAL SERVICE LINERS 22. NAME AND ADDRESS OF FACILITY
Hines-Rinaldi Funeral Home 11800 New Hampshire Ave., Silver Spring, MD the 1 removal medical 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, filled in by shock, or heart fellure. List only one ceuse on each line 0 **IMMEDIATE CAUSE (Final** the cremation, disease or condition STOKE completely traumatic event, resulting in death) OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with bunal, CERTIFICATION and Sequentially list conditions, prior to If any, leading to immediate the attending physician Mental Hygiene prior to cause. Enter UNDERLYING CAUSE (Disease or Injury 0 5401 other 1 DUE TO (DR AS A CONSEDUENCE OF) that initiated eventa reaulting in death) LAST 6 PART II. Other algorificent conditions Contributing to death but not resulting in the underlying ceusa given in Part I. 24a. WAS AN AUTOPSY PERFORMED? PHYSICIAN: MEDICAL P P enscon shows any Health a LYES 2 DING has been s Dept. of H DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES □ NO □ UNCERTAIN ☑ 28. PLACE OF OEATH (Check only one) 25. WAS CASE REFERRED, TO MEDICAL **Item** certificate I EXAMINER? HOSPITAL: OTHER: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 5 Reeldence 8 Other (Specify) 6 the 27. MANNED OF DEATH 28e. DATE OF INJURY 28b. TIME DF 28c. INJURY AT WORK? 28d, OESCRIBE HOW INJURY OCCURED this ce with th marked, 1 Natural NI 1 THES A IND NA BY After 2 Accident investigation 28e. PLACE OF INJURY - At home, farm, atreet, factory, office 3 Sulcide 28f. LOCATION (Street and Number or Rural Route Number FUNERAL OIRECTOR: A within 72 hours after de 28 is 6 Could not be COMPLETED 4 Homicide 29a. CERTIFIER

**Chack note: 1 CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner se stated. HOSPITAL TO THE HOSPITA
TO THE FUNERA
De filed within 72
IMPORTANT: II 2 MEDICAL EXAMINER: On the basic of exemination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(e) and manner ee stated. 296. SIGNATURE AND TITLE OF CERTIFIER 29c LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE December 4199 DORESS OF PERSON WND COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Byoung K. Lee, MD 13000 Georgia Avenue, Silver Spring, Maryland 20906-5330 31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

8. AGE (In yrs. last birthday

DHMH-16 Rev 1/89

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BALTIMORE, MARYLAND 21215-0020

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X 687	execute
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o, o	death
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OF VI	PHYSICIAN:
DIVISION OF VITAL RECORDS, P.O. BOX 68760	HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours at
	OR
	HOSPITAL
	44

31. DATE FILED (Month, Day, Year)

04 1995

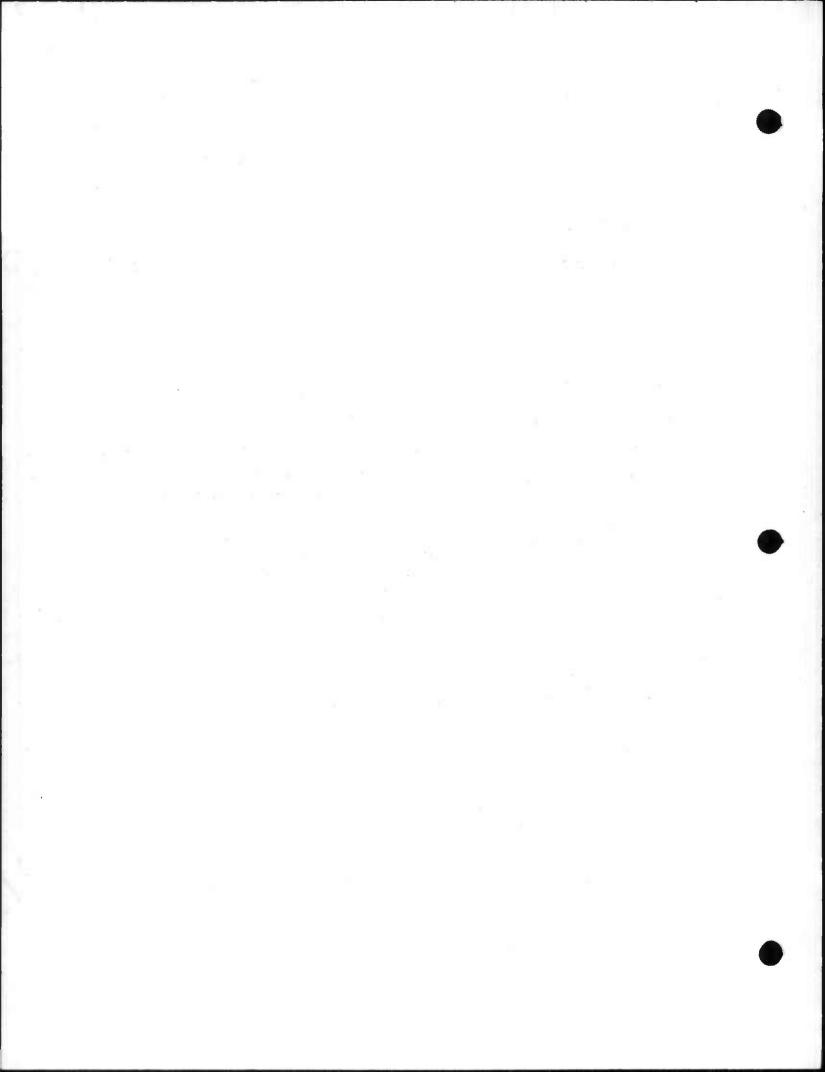
32. REGISTRAR'S SIGNATURE

Devolus Ro

Julia

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE **CERTIFICATE OF DEATH** REG. NO. 1. DECEDENT'S NAME (First Micidle Last) 2. DATE OF DEATH 3. TIME OF DEATH 1995 Dean Manaugh December 1:41 4. SOCIAL SECURITY NUMBER 7. DATE OF BIRTH (Month, Day, Year Dec. 2, S. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign 219-56-0216 DAYS 1 X M 2 - F 45 1950 Washington, Se. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Pages 1, 2, 3 Montgomery General Hospital Olnev Montgomery RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Silver Spring Montgomery 1 YES 2 X NO permit. 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 20906 use as the burial-transit ll Baileys Court United States retained by the hospital or attending physician. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, White, etc. FORCES? 1 YES 2 YHO 1 Never Married 2 Married If yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 YES 2 Y NO Specify. BY Specify 3 Widowed 4 Divorced White ETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only his funeral director, page 5 should be detached for intary/Secondary (0-12) College (1-4 or 5+) COMPL WSSC Construction Supervisor 17. FATHER'S NAME (First, Middle, Lest) 18. MOTHER'S NAME (First, Middle, Meiden Surneme) James Nelson 7 Manaugh Elaine Brower Cook notified 194. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street end Number or Rural Route Number, City or Town, State, Zip Code) 0 Merle Ann Tigert-Manaugh Same as 10 death. Page 6 may be 9 20e. METHOD OF DISPOSITION
1 Duriel 2 Cremation 3 D 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State must DATE metery, crematory or other place) Chesapeake Crematory 12-3 4 Donation 5 Other (Specify) Beltsville, Maryland examiner 21, SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Rapp Funeral Services, P. A. lees filled in by the fion, or removal. 933 Gist Avenue, Silver Spring, MD 20910 shows any injury, or other traumatic event, the medical 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fallure. List only one cause on each line. interval Between cremation, or IMMEDIATE CAUSE (Final Onset and Death disease or condition resulting in deeth) .Bi an and completely fir to burial, cremation ateral Preunoma (Aspenjillus, AFB, Nerseria Week DUE TO (OR AS A CONSEQUENCE OF): Moraxolla Catarrhalis) Merring tids CERTIFICATION Sequentially list conditions. If sny, leading to immediate cause. Enter UNDERLYING physician prior Multi System organ fair CAUSE (Disease or injury by the attending phy and Mental Hygiene that initiated events resulting in death) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. MEDICAL 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS Brainstem Gliana AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? PERFORMED? Signed Health a 1 TES 2 NO Heparitis (1 YES 2 NO 6 DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO W UNCERTAIN PHYSICIAN: has be Dept. 23 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) EXAMINER? certificate ? HOSPITAL OTHER: patient 2 ER/Outpatie 3 DOA 4 Nursing Home 5 Residence 8 Other (Specify) marked, or 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT 28d. DESCRIBE HOW INJURY OCCURED this c 5 Pending Investigation Natural 1 YES 2 NO After 1 BY Accident TO THE HOSPITAL OR ATTENDING TO THE FUNERAL DIRECTOR: Afte be fied within 72 hours after deal IMPORTANT: If Item 28 Is m 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 281. LOCATION (Street end Number or Rural Route Number, City or Town. State) COMPLETED 8 Could not be 29e. CERTIFIER best of my knowledge, death occurred at the time, date end place, end due to the cause(e) end mariner ee stated. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE 35045 December 3, 1995 Altending Internest 2 IS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) PHILLP G. Henjum, MD 3416 Oland wood Ct. #200 Olney mD 20832

DHMH-16 Rev 1/89



REGISTRAR		CI	:KIIF	ICATE (OF DEATH	1	REG. NO.			
1. DECEDENT'S NAME (First, Middle, Lest)						2. DATE OF MONTH	DEATH	YEAR	3. TIME OF DEATH	
Judith	Ann McC	oy					ber 4,		5:10 A.	
4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. les	t birthday)	IF UNDER 1 YE		7. DATE OF	BIRTH	8. BIRT	HPLACE (State or Foreign	
266-63-3234	1 M 2 K F	50	YRS.		YS HOURA MIN.		4, 1945	_	nsylvania	
99. FACILITY NAME (If not institution, give					wn or Location of t thersburg	DEATH		ounty of	omery	
RESIDENCE OF DECEDENT 10a. STATE 10b. COUN	тү		10c, CIT	Y, TOWN OR L	OCATION				10d. INSIDE CITY	
	ntgomery			Gaithe	rsburg				LIMITS? 1 YES 2 X NO	
10a. STREET AND NUMBER 19323 Club Hous	e Road, #	101			10f. ZIP CODE 20879		1		itizen of what country?	
11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	If yo	AS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— yes, specify Cuban, Mexican, Puerto Rican, etc.) YES 2 X NO Specify: White								
15. DECEDENT'S ED (Specify only highest grad		(G	ive kind of I	USUAL OCCU	PATION ig most of working	16b. KI	ND OF BUSINESS	INDUSTRY		
Elementery/Secondary (0-12)	College (1-4 or 5 +	life	Non	se retired.)		N/	N/A			
17. FATHER'S NAME (First, Middle, Last)			HOL		16. MOTHER'S N	AME (First, Mide	dle, Maiden Surnam			
William	Edward	McCoy				Ruth	Breen			
19s. INFORMANT'S NAME (Type/Print)					reet and Number or Rura					
Ruth McCoy 20s. METHOD OF DISPOSITION							Gaithe:		g,MD. 20879	
1 Buriel 2 X Cremetion 3 Re 4 Donation 5 Other (Specify)	moval from State	cemetery.cre	matory or o	OF DISPOSITIO		1			own, State Virginia	
21. SIGNATURE OF FUNERAL SERVICE L	ICENSEE (Metro	DOTI		ematory E AND ADDRESS OF F					
Mucha	(1)(9	elle	w	10.1	Door Per		Vol Fun		ноme g, MD. 2087	
23. PART I. Enter the disesses, or shock, or heart failure									Approximate interval Between	
iMMEDIATE CAUSE (Final disease or condition resulting in death)	. Metast	atic Co	lon (Carcin	oma				Oneat and Deat	
	DUE TO	(OR AS A CONSE	OUENCE O	F):						
Sequentially list conditions,	b	(OR AS A CONSE	OUENCE O	EI.						
if any, leading to immediate cause. Enter UNDERLYING									į	
CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO	(OR AS A CONSE	OUENCE D	F):						
PART II. Other aignificant condition	ona contributing to	death but not a	resulting	in the under	lying cause given i	n Part I 2	In. WAS AN AUTOP	BV 24	b. WERE AUTOPSY FINDINGS	
							PERFORMED?		AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?	
					THE				1 YES 2 NO	
DID TOBACCO USE CON	TRIBUTE TO CA			TH (Check only		IN L				
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO	HOSPITAL:			OTHER:	Home 5 X Residence	8 ☐ Other (S	Specify)	:		
27. MANNER OF DEATH	28s. DATE OF (Month, D.	INJURY	28b. TIM		:. INJURY AT WORK?		RIBE HOW INJURY	OCCURED		
1 X Natural 5 Pending 2 Accident Investigation		ay, roury	1144		YES 2 NO					
3 Suicide 6 Could not be 4 Homicide determined		F INJURY — At he atc. (Specify)	ome, ferm,	street, factory,	offica		ON (Street and Nun Town, State)	nber or Rura	Route Number,	
29e. CERTIFIER (Check only one) 1 X CERTIFYING PHY									(a) and manner as stated.	
DIE MONATURE AND TITLE OF CERTIF		_			29c. LICENSE N				D (Month, Day, Year)	
James 6.15	roome	un)			5077	25			ber 4, 1995	
DO NAME AND ADDRESS OF PERSON W	HO COMPLETED CAUS	SE OF DEATH (ITE) #20	O Pa-				
James A. Brown, 31. DATE FILED (Month, Day, Year)	M.D., 970	SE OF DEATH (ITE	al Ce) 077 Drive, #30	0, Roc				

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 5 may be retained by the hospital or attending physician.

TO THE FUNEDAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunal-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to bunal, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

•	FOR STATE REGIS
	1. DECEDENT
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	9a, FACILITY
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	RESIDEN
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ı	11. MARITAL
ı	1 Never I

	HEGISTHAN		CE	- Direction	CALE	JF U	EAIN		HEG. NO			
	1. DECEDENT'S HAME (First, Middle, Last)							2. DATE	2. DATE OF DEATH MONTH DAY YEAR 3. TIME OF DEATH			3. TIME OF DEATH
JR	LYDIA BROWN			MAGOWAN			NOV. 30, 1995		5:20 am M			
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. les	t birthday)	IF UNDER 1 YE		F UNDER 24 HRS	48.6	DE BIRTH		8. BIRTHP	LACE (State or Foreign
	578-44-8082	t 🗆 M 2 💢 F	87	YRS.	MONTHS DA	N/B 34	OURS MIN.	Marc	h 28,	19081	Vest	Virginia
	9a, FACILITY HAME (If not institution, give st	reet and number)			9b. CITY, TO	WN OR I	LOCATION OF	DEATH		9c. COUNTY OF DEATH		
	Washington Adventist Hospital				Takoma Park			Mon	tgome	rv		
5	RESIDENCE OF DECEDENT											
DIRECTOR	10e, STATE 10b, COUNTY			10c. CIT	Y, TOWN OR LOCATION						10d. INSIDE CITY LIMITS?	
						yattsville					t X YES 2 HO	
¥	10e. STREET AND HUMBER					101. ZI	P CODE			10g. CIT	IZEN OF WH	HAT COUNTRY?
FUNERAL	7429 17th Avenue					20	783			Uni	ted S	States
5	11. MARITAL STATUS 12. WAS DECEDENT EVER IH U.S. ARMED FORCES? 1 YES 2 Y HO				13. WAS DECEMBENT OF HISPANIC ORIGIN? (Specify Viller, 1998, specify Cuban, Maxican, Puerto Rican, etc.)				s or No—	14. RACE - Black.	- American Indian, White, etc.	
BY F	1 Never Married 2 Merried 3 X Widowed 4 Divorced	IF YES, GIVE V			t TES 2 X HO Specify:			mount, ency		Specify	r:	
												Lored
E	15. DECEDENT'S EDU- (Specify only highest grade	CATIOH completed)	(G	ive kind of v	VORK done during	PATIOH og most o	of working	16b.	KIHD OF BU	SIHESS/IH	DUSTRY	
E	Elementary/Secondary (0-12)	College (1-4 or 5	+)	Do NOT us				1 .				
MP		4	Te	ache	r				ublic		ols	
COMPLETED	t7. FATHER'S HAME (First, Middle, Last)				18. MOTHER'S NAME (First, Middle, Maiden Surname)							
H	William A. Brown							e Bla				
2	19a. INFORMANT'S HAME (Type/Print)		190				Number or Rur					
	Ronald H. Davis											D.C. 20009
	20e, METHOD OF DISPOSITION 1 (A Burlel 2 Cremetton 3 Rem	oval from State	cemetery, cre	and DATE (of disposition ther place) Memori	N (Name	of	DAT	20c. LC	CATION —	- City or Tow	rn, Stata
	4 Donation 6 Other (Specify)		_ Harm	lony				1,54/	Lar	idove	r, Ma	ryland
					McGu	ire	ADDRESS OF Funer	al Se	rvice,	Inc		20012
	Dynne a.	Mega	we		7400	Ge	orgia	Ave.	N.W.,	Wash	ingto	on, D.C.
	23. PART I. Enter the diseases, or											Approximate
	shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final Onset and Death											
	disease or condition The suiting in death) But TO (OR AS A CONSEQUENCE OF):											
	DUE TO (OR AS A CONSEQUENCE OF):											
z	COCON CANCEIS											
CERTIFICATION	Sequentially list conditions, DUE TO (OR AS A COHSCOUENCE OF):											
3	cause. Enter UNDERLYING DN F C MON A											
E	fulf luftlefor exemp											
E	resulting in death) LAST											
	PART ii Other algorificant condition	na contributing to	death but not a	resulting	in the unde	rivino e	cause given	in Part I	24n W8 9 41	VARITIONS	24h	WERE AUTOPSY FINDINGS
EDICAL												
ă	1 YES 2 TWO								OF DEATH?			
Σ	HYPERGENSION											
Z	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN U											
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER? OTHER:											
YS	1 TYES 2 7500	-	ER/Outpatient 3		-		5 Residen	-				
F	27. MANNER OF DEATH 1 Metural 5 Pending	26a. DATE Of (Month, i	Day, Year)	28b. TIN	JURY	WORK	(?	26d. DES	CRIBE HOW	W INJURY OCCURED		
ВУ	2 Accident Investigation						S 2 HO					
8	3 Suicide 6 Could not be 4 Homicide datarmined				atreet, factory, offica			261. LOCATION (Street and Number or Rural Route Number, City or Town, State)			oute Number,	
COMPLET	29s. CERTIFIER (Check only 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and menner as stated.											
OM	2 MEDICAL EXAMINER: On the beals of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and menner as stated.											
EC	296, GIGNATURE AND TITLE OF CERTIFIER 296, DATE SIGNED (Month, Day, Year)											
0	Chroleta K 541 HA KAN D 1997) 11/36/95											
5	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Typo. Print) PY 6 H 230 MAKOMA JARK											
	K' 200414 KIS JEIO CULKOIT 4 AB WIS EDUIS											
	31. DATE FILED (Month, Day, Year)	32. REGISTR	AR'S SIGNATURE	1,11								
	DEC NO 1001	5 Julia d	Muchan Ra	work.								



YEAR

3. TIME OF DEATH

REG. NO.

2. DATE OF DEATN

STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

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DECEMBER "I MASALLE LEWIS 1995 7:20 PM 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. lest birthdey) 7. DATE OF BIRTH (Month, Day, Year) JAN. 1, 1922 IF UNDER 1 YEAR | IF UNDER 24 HRS. 8. BIRTNPLACE (State or Foreign HOURS 184-18-5390 1 🕅 M 2 🗌 F 73 PA Pages 1, 2, 3 should Se. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATN 9c. COUNTY OF DEATH DIRECTOR PRINCE GEORGES GEN. HOSP'T. CHEVERLY PRINCE GEORGES RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? MD. PRINCE GEORGES HYATTSVILLE 1 YES 2 NO permit. FUNERAL 10e STREET AND NUMBER 101. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? burial-transit 4904 66th AVE. 20781 U.S.A. death. Page 6 may be retained by the hospital or attending physician. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-14. RACE — American Indian, Black, White, etc. If yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 YES 2 NO Specify: Never Married 2 Married IF YES, GIVE WAR OR DATES 3 Widowed 4 Divorced BY use as the WHITE COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade comple 16e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) detached for College (1-4 or 5+) ELECTRICIAN HOME APPLIANCES once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) H page 5 should be UNKNOWN UNKNOWN BE notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) ROBERT COTHAM 2409 DANCY DR. NORTH, FORTWORTH, TX.76131 99 20a. METHOD OF DISPOSITION
1 ☐ Burlat 2 X Cremation 3 ☐ Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, Stata DATE must funeral director, CHAMBERS CREMATORY 12/1 RIVERDALE, MD. 4 Donation 5 Other (Specify) examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSE 22. NAME AND ADDRESS OF FACILITY 20737 M00091 W. W. CHAMBERS CO., RIVERDALE, MD. completely filled in by the medical 23. PART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory arrest, ahock, or heart fallure. List only one cause on each line. 0 **Onset and Death IMMEDIATE CAUSE (Final** the cremation, disease or condition resulting in death) event, to burial, erlansine 20 /a traumatic and CERTIFICATION Sequentielly list conditions, TO (OR AS A CONSEQUENCE OF): If any, laading to immediate cause. Entar UNDERLYING physician prior CAUSE (Disease or Injury other DUE TO (OR AS A CONSEQUENCE OF) Mental Hygiene that initieted events resulting in deeth) LAST 0 Injury, PART II. Other aignificant conditions contributing to deeth but not resulting in the underlying cause given in Part i. 24s. WAS AN AUTOPSY WERE AUTOPSY FINDINGS een signed by the AVAILABLE PRIOR TO COMPLETION OF GAUSE DF DEATN? PERFORMED? shows any 1 YES 2 NO in 1 YES 2 NO peen DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: Dept. 23 has 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATN (Check only one) certificate h Item **EXAMINER?** HOSPITAL:
1 X Inpatient 2 DER/Outpatient 3 DOA OTHER: 1 YES 2 NO 4 Nursing Home 5 Residence 8 Other (Specify) 6 27. MANNER OF DEATN 28b. TIME OF INJURY 28a. DATE OF INJURY 28c. INJURY AT 28d. DESCRIBE NOW INJURY OCCURED marked, with with 1 Natural 5 Pending Investigation м 1 YES 2 NO death v BY 2 Accident 28s. PLACE OF INJURY — At home, farm, street, factory, offica building, etc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 89 3 Suicide 8 Could not be COMPLETED DIRECTOR: hours after 28 4 Nomicide determined item 29a. CERTIFIER 1 CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as attend. TO THE HOSPITAL ITO THE FUNERAL ID BE filed within 72 h 2 MEDICAL EXAMINER: On the tion end/or investigation, in my opinion, death occured at the time, date and place, end due to the cause(a) end manner as stated BE 2 san Y.D. 31. DATE FILED (Month, DavAlber) DNMN-18 Ray 1/89

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

era su.) 7 r π U

5 may be retained by the hospital or attending physician. tor, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760.

THE COURT, T.O. BOX OF SO,	TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hosp	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
	TO THE HOSPITAL DR ATTENDING PHYSICIAN:	TO THE FUNERAL DIRECTOR: After this certific be filed within 72 hours after death with the S	IMPORTANT: If item 28 is marked, or i

	FOR STATE REGISTRAR	STATE OF MARYLANI	D / DEPARTI			MENTAL HYGIENI REG. NO.	E		
	1. DECEDENT'S NAME (First, Middle, Last)						2. DATE OF DEATH 3. TIME OF DEATH		
	Eva	Monsein			Dec. 2, 19	6:30 a M			
		5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS.				7. DATE OF BIRTN (Month, Day, Year)	RTHPLACE (State or Foreign		
	100-00-3313	1 M 2 DLF 88 YRS.			HOURS MIN.	8-5-07	entucky		
~	9a. FACILITY NAME (If not institution, give street		9		R LOCATION OF DE	ATN	F DEATH		
DIRECTOR	10714 Potomac Tennis Lane Potomac					Montgomery			
EC	10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LO				LOCATION			10d. INSIDE CITY	
	Md. Montgo	mery	Betl	hesda				LIMITS?	
AL	10e. STREET AND NUMBER			100	. ZIP CODE		10g. CITIZEN C	OF WHAT COUNTRY?	
FUNERAL	7108 Nevis Rd.			20817			USA		
	1 Never Married 2 Married	2. WAS DECEDENT EVER IN U.S. FORCES? 1 YES 2- IF YES, GIVE WAR OR DATES	NO NO	If yes, sp	ocify_Cuban, Mexican	IC ORIGIN? (Specify Yes n, Puerto Rican, etc.)	B	ACE — American Indian, llack, White, atc.	
D BY	3 Wildowed 4 Divorced	m ====================================					Specify: White		
COMPLETED	15. DECEDENT'S EDUCAT (Specify only highest grade con	mpleted)	(Give kind of work life. Do NOT use n	k done durina ma	ON st of working	16b. KIND OF BUS	INESS/INDUSTR	Υ	
2	Elementary/Secondary (U-12) College (1-4 of 5 +)			Housewife			Housewife		
OM	17. FATNER'S NAME (First, Middle, Last)				18. MOTNER'S NAM	AE (First, Middle, Maiden S	Surname)		
BE C	Sam Shap	oiro			16. MOTNER'S NAME (First, Middle, Meiden Surneme) Sarah Katz				
TO B	19a. INFORMANT'S NAME (Type/Print)		19b. MAILING AC	DDRESS (Street a	nd Number or Rural R	oute Number, City or Town	, State, Zip Code)	
-	Irwin Monsei	.n	7108	Nevis	Rd. Beth	esda, Md.	20817		
	20a. METNOD OF DISPOSITION 1	I from Stata 20b.PLA camatery K1N	CEAND DATE OF I	DISPOSITION (Na r place) Mem Ga	med irdens		s Chur	Car Comme	
	21. SIGNATURE OF FUNERAL SERVICE LIGHT			22. NAME AP	ID ADDRESS OF FAC	HLITY			
	Elill					Funeral Di Pike Rock			
	23. PART i. Enter the diseases, of com	nplications that caused the	death. Do not	enter the mo	de of dying, such	as cardiac or reapir	atory arreat,	Approximate	
	23. PART i. Enter the diseases, of complications that caused the death. Do not enter the mode of dying, such as cardiac or reapiratory arreat, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final							interval Between Onset and Death	
	disease or condition resulting in death) a. a. a. a.							months	
	DUE TO (OR AS A CONSEQUENCE OF):								
CERTIFICATION	Sequentially list conditions, if any, leading to immediate b. Sequentially list conditions, if any, leading to immediate								
S	cause. Enter UNDERLYING CAUSE (Disease or Injury								
	that initiated eventa DUE TO (DR AS A CONSEQUENCE OF): resulting in death) LAST								
	d								
¥	PART ii. Other significant conditions of	ontributing to death but n	ot resulting in t	the underlying	cause given in F	Part i. 24s. WAS AN A PERFORM		24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO	
PHYSICIAN: MEDIC	grove asperation					1 _ YES 2	1 TYES 2 SONO OF D		
Σ							1 TYES 2 NO		
AN	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one)								
Sici	EXAMINER? 1 YES 2 PAO HOSPITAL: 1 Inpetiant 2 ER/Outpetiant 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify)								
Ě	27. MANNER OF DEATH	28a. DATE OF INJURY	26b. TIME C	OF 28c, INJ	URY AT	26d. DESCRIBE NOW IN	JURY OCCURED		
ВУ Р	1 Netural 5 Pending 2 Accident Investigation	(Month, Day, Year)	INJUR		RK? 'ES 2 NO				
	3 Suicide s Could not be detarmined 4 Homicide detarmined			ca 281. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
COMPLET	29a. CERTIFIER (Check only one). 1 CERTIFIER (Check only one). 2 MEDICAL EXAMINER: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, data and placa, and due to the cause(a) and manner as stated.								
BEC	296. SIGNATURE AND TITLE OF CENTIFIER	29d. DATE SIGN	DATE SIGNED (Month, Day, Year)						
ဥ	1) 37/18/								
	on. Michael Grady				ashingtor	DC 20016	7		
	31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATUR	NE -	C TANA AA	ADITITIO COL	1 1/2 20016			
	DEC 06 1995	Jalia Davelson	Randolf						

page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should

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requires that the death certif	een signed by the attending g of Health and Mental Hynien	shows any injury, or other
law requires that the death certif	as been signed by the attending short of Health and Mental Hymien	23 shows any injury, or other
The law requires that the death certif	te has been signed by the attending g	em 23 shows any injury, or oth
AN: The law requires that the death certif	ificate has been signed by the attending a state here of Health and Mental Hunjen	r item 23 shows any injury, or other
SICIAN: The law requires that the death certif	certificate has been signed by the attending of the State Deet of Health and Mental Hymien	I, or item 23 shows any injury, or other
PHYSICIAN: The law requires that the death certif	this certificate has been signed by the attending a with the State Dent of Health and Mental Hynien	ked, or item 23 shows any injury, or other
4G PHYSICIAN: The law requires that the death certif	ter this certificate has been signed by the attending and with the State Dent of Health and Mental Hymien	marked, or item 23 shows any injury, or other
NDING PHYSICIAN: The law requires that the death certif	3. After this certificate has been signed by the attending a clearh with the State Dent of Health and Merital Hydison	is marked, or item 23 shows any injury, or other
TTENDING PHYSICIAN: The law requires that the death certif	STOR: After this certificate has been signed by the attending a pater death with the State Dent of Health and Mental Hydien	28 is marked, or item 23 shows any injury, or other
IR ATTENDING PHYSICIAN: The law requires that the death certif	IRECTOR: After this certificate has been signed by the attending sure after death with the State Dent of Health and Mental Hydien	em 28 is marked, or item 23 shows any injury, or oth
L OR ATTENDING PHYSICIAN: The law requires that the death certif	L DIRECTOR: After this certificate has been signed by the attending strong and many with the State Dent of Health and Mental Humien	I item 28 is marked, or item 23 shows any injury, or other
PITAL OR ATTENDING PHYSICIAN; The law requires that the death certif	ERAL DIRECTOR: After this certificate has been signed by the attending is a pours after death with the State Dent of Health and Mental House	T. If Item 28 is marked, or item 23 shows any injury, or other
HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certif	-UNERAL DIRECTOR: After this certificate has been signed by the attending is other 22 hours after death with the State Dent of Health and Mental Hydien	ANT: if item 28 is marked, or item 23 shows any injury, or other
4E HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certif	HE FUNERAL DIRECTOR: After this certificate has been signed by the attending a within 72 hours after death with the State Dent of Health and Merial Myrian	ORTANT: If Item 28 is marked, or item 23 shows any injury, or other
THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed witum 24 hours after death. Page 6 may be retained by the hosp	THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached anything 20 hours after death with the State Dent of Health and Mental Housine orior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	1 - FOR STATE OF MARYL REGISTRAR		NT OF HEALTH AND I	MENTAL HYGIENE REG. NO.					
	1. OECEDENT'S NAME (First, Middle, Last)		ORE	2. DATE OF DEATH MONTH DAY	Y YEAR	3. TIME OF DEATH			
	CHRISTINE VIRGINI	<i>[</i>]	DECEMBER 4	7:30 A M					
DIRECTOR		MONTH	DER 1 YEAR IF UNDER 24 HRS.	7. OATE OF BIRTH (Month, Day, Year)	Cou	THPLACE (State or Foreign ntry)			
	220-34-4036 1 L M 2 X F 8. 9e. FACILITY NAME (if not institution, give street and number)		ITY, TOWN OR LOCATION OF DE	May 14, 19	9c. COUNTY OF	shington, DC			
	6001 37th Avenue					PRINCE GEORGE'S			
	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY								
E I						LIMITS?			
	10e. STREET AND NUMBER		yattsville 101. ZIP CODE		10g. CITIZEN OF	WHAT COUNTRY?			
FUNERAL	6001 37th Avenue		20782		U.S.A				
5	11. MARITAL STATUS 1 Never Married 2 Married 12. WAS DECEDENT EVER FORCES? 1 YES	N U.S. ARMED 2 X NO	13. WAS DECENDENT OF HISPAN If yes, specify Cuben, Mexica		or No- 14. RA	CE — American Indian, ick, White, atc.			
B	3 ☑ Widowed 4 ☐ Divorced IF YES, GIVE WAR OR D	ATES	1 YES 2 NO Specifi	y:	Specify: White				
ED	15. OECEDENT'S EDUCATION (Specify only highest grade completed)	16a. DECEDENT'S USUAL	OCCUPATION ne during most of working	16b. KIND OF BUS	INESS/INDUSTRY	***************************************			
COMPLETED	Elementary/Secondary (0-12) College (1-4 or 5+)	d.)	77 - 1 - 1						
MP	1.2	Manager	Hecht ME (First, Middle, Maiden S						
	Roy F. Edelyn			Louise Abe		n			
) BE	19a. INFORMANT'S NAME (Type/Print)	19b. MAILING ADDR	ESS (Street and Number or Rural						
임	Gail Frazier	15725 Mi	llbrook Lane,	Laurel, Ma	ryland	20707			
		o. PLACE AND DATE OF DISI metery, cremetory or other pla Ort Lincoln	and and	1	CATION City or				
	4 Donetion 5 Other (Specify) F'(//	22. NAME AND ADDRESS OF FA						
	· Clique I R PO	Marie I	Francis Gasch						
_	23. PART I. Enter the diseases, or complications that cause		4739 Baltimore			Approximata			
	ahock, or heart failure. List only one ceuse Dn eech line. Interval Between Onset and Death								
	disease or condition resulting in death) a. MYOCARDIAL INFARCTION Due TO (OR AS A CONSEQUENCE OF):								
NO.	Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): JEANS AS A CONSEQUENCE OF):								
CAT	cause. Enter UNDERLYING								
Ĕ	CAUSE (Disease or Injury that initiated events DUE TO (OR AS A CONSEQUENCE OF):								
CERTIFICATION	resulting in death) LAST								
ALC	PART II. Other significant conditions contributing to deeth	out not resulting in the	underlying cause given in	Part i. 24a. WAS AN A		4b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO			
	1 TES 2 NO					COMPLETION OF CAUSE DF DEATH?			
ME	DID TORACCO LICE CONTRIBUTE TO CALLER	DE DEATH VEG T	I NO PY UNICEDIAL			1 YES 2 NO			
AN	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO W UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one)								
PHYSICIAN: MEDIC	EXAMINER? 1 YES 2 NO 1 inpetient 2 ER/Out		IER: Nursing Home 5 N Residence	8 Other (Specify)					
품	27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF	28c. INJURY AT WORK?	28d. DESCRIBE HOW IN	JURY OCCURED				
BY	1 Natural 5 Pending 2 Accident Investigation	P	1 YES 2 ND						
	3 Suicide 6 Could not be 26a. PLACE OF INJUR building, stc. (Spr 4 Homicide detarmined	factory, offica	Ica 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)						
COMPLETED	29a. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, dasth occurred at the time, data and place, and due to the cause(s) and manner as stated.								
MP	(Check only one) MEDICAL EXAMINER: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated.								
	29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year)								
O BE	Allseyer MD	_MD D25925 Dec 4,							
5	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF D J. BERGER # 205, 7720	EATH (ITEM 27) (Type, Print) WISCONSI	N Ave, BeTh	esda, md	208	74			
	31. DATE FILED (Month, Day, Year) 32. BEGISTRA'S SIG		, ,	,		7]			
	DEC 8 1995 Sala 2000								

And the same of a fine of the same of the

BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

THE MOSTIAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE PHYSIAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept, of Health and Memtal Hygiene prior to burial, cremation, or removal.

IMPORTANT: It item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

	1. DECEDENT'S NAME (First	. Middle, Last)			02.	THE TOA	TE OI	DLA		A DATE OF BEATH				
	Helen Loui		1.017							2. DATE OF DEATH DA		YEAR	3. TIME OF DEATH	
	4. SOCIAL SECURITY NUMBER		5. SEX	0.005.0							4, 1995 4:35 A M			
			71.55-5		n yrs. last bir	MONTH	DER 1 YEAR	IF UNDER	24 HRS.	7. DATE OF SIRTH (Month, Day, Year)		6. BIRTHP Country)	LACE (State or Foreign	
	233-54-8804		1 M 2 F		76	YRS.					ept. 14,1919 West Virgi			
-	9a. FACILITY NAME (If not in					9b. C	ITY, TOWH	OR LOCATION	ON OF DE	ATH	9c. COU	NTY OF DE		
DIRECTOR	Crofton Con	valesc	ent Cent	er]	Croft	on			Ann	e Aru	ndel	
[5]	RESIDENCE OF DEC	10b. COUNT	,		1									
32)				1		LIN					IOd, INSIDE CITY LIMITS?		
	Maryland		Arundel				Croft	on					☐ YES 2 ☑ NO	
ĭ¥.	10e. STREET AND NUMBER						10	f. ZIP CODE	E		10g. CIT	ZEN OF WH	AT COUNTRY?	
Ä	2131 Davids	onvill	e Road					21114	4		U.S	. A .		
FUNERAL	11. MARITAL STATUS		12. WAS DECEDEN FORCES? 1		U.S. ARMEI	D 1	13. WAS DE	CENDENT O	F HISPAN	IC ORIGIN? (Specify Yes		14. RACE -	- American Indian,	
BY	1 Never Married 2 3 Widowed 4 Divo		IF YES, GIVE W					ocify Cuba 3 2 ⊠ NO		, Puerto Rican, etc.)		Slack, Specify	White, etc.	
	3 E3 WIGOWEG 4 DIVE	HCGG											White	
E C	16, DEC (Specify onl)	EDENT'S EDU y highest grade	CATION completed)		(Glym 6	DENT'S USUAL	no disting m	ON ost of workin	107	16b. KINO OF SUS	HNESS/ING	DUSTRY		
<u> </u>	Elementary/Secondary (0	1-12)	College (1-4 or 5 -	-)	life. Do	NOT use retired	d.)							
M M	9				Homen	naker				0wn	Home			
COMPLET	17. FATHER'S NAME (First, M	111						18. MOTH	HER'S NAM	ME (First, Middle, Maiden	Sumame)			
ш	Mike Va	rgo							Mary	Kuba				
8	19a. INFORMANT'S NAME (ype/Print)			19b. M	AILING ADDRE	ESS (Street	and Number		oute Number, City or Town	n, State, Zip	Code)		
2	David A. Mol	1ey			110	06 Red	Fal1	s Lar	ie. C	Sambrills,	Mars	Jand	21054	
	20a, METHOD OF DISPOSIT			20b. F	PLACE AND	DATE OF DISP	OSITION /N							
	20b. PLACE AND DATE Of DISPOSITION 1 Disposition 2 Cremetion 3 Removel from State 4 Donetion 6 Other (Specify) 20b. PLACE AND DATE Of DISPOSITION Name of Gemetery, cremetory or other place) Fort Lincoln Cemetery 12/06/95 Brentwood, Maryland													
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY													
	DO	7 /	0000		,	I	Franc	is Ga	isch'	s Sons Fu	nera]	L Homa	P.A.	
	May	es t.	124	1		4	4739	Balti	more	Ave. Hvai	ttsvi	110	MD 20781	
	23. PART i. Enter the d	iseases, or o	complications that List only one cau	t caused	the deeth	. Do not ent	ter the mo	ods of dyl	ng, such	ss cardiac or respi	ratory an	rest,	Approximate	
	IMMEDIATE CAUSE (Fir		List only one cau	A On eac	cn line.	Δ							Onest and Death	
	disease or condition													
	DUE TO (OR AS A CONSEQUENCE OF):													
Z	Sequentially, lies and delegation 6.													
CERTIFICATION	Sequentially list conditi	Sequentially list conditions, if any, leading to immediate OUE TO (OR AS A CONSEQUENCE OF):												
3	cause. Enter UNDERLY	NG												
Ē	CAUSE (Disease or Injuthat initiated events		DUE TO	(OR AS A C	CONSEQUE	NCE OF):								
E E	resulting in death) LAS	T .	1,											
	PART II Other steelder			4										
MEDICAL	PART ii. Other significa	ent condition	contributing to	geeth but	t not reau	itting in the	underlyin	g csuse g	lven in F	Part I, 24s, WAS AN PERFOR			YERE AUTOPSY FINDINGS	
8	l									1 YES 2	_	0	OMPLETION DF CAUSE F DEATH?	
W													YES 2 NO	
	DID TOBACCO U	SE CONTI	RIBUTE TO CA	USE OF	DEATH	YES 🗆	NO P	UNC	ERTAIN					
X	25. WAS CASE REFERRED TO EXAMINER?					F DEATH (Chec								
PHYSICIAN:	1 VES 2 NO		HOSPITAL:	ER/Outpat	tiant 3 🗆 (DOA 4 N		o 5∏ P=	sidence d	Other (Specify)				
	27. MANNER OF DEATH		28a. DATE OF	INJURY	-	Bb. TIME OF	26c. IN.	URY AT		28d. DESCRIBE HOW II	JURY OC	CURED		
		Pending	(Month, Di	ay, Year)		INJURY	WC	YES 2	NO			- 5.1.2.5		
ВУ	2 Sudelde	Investigation	28e. PLACE O	F INJURY -	- At home.	form, etreet, to			+	284 LOCATION (Street o	ad Number	or Prival Bo	to Mumbas	
	3 Suicide 8 Could not be 28e. PLACE OF INJURY — At home, farm, atrast, fectory, office building, etc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City of Town State)										u rvumber	or Hursil MOL	NO NUMBER,	
		4 Countries Controlled												
Ш	4 Homicide			29s. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and piace, and due to the cause(a) and manner as stated, 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and piace, and due to the cause(a) and manner as stated.										
MPLE	4 Homicide 29a. CERTIFIER (Check only 1 ERTI	FYING PHYSI												
OMPLE	4 Homicide 29a. CERTIFIER (Check only 1 ERTI	FYING PHYSI											nd manner sa stated,	
E COMPLET	4 Homicide 29a. CERTIFIER (Check only 1 ERTI	FYING PHYSI						leath occur	ed at the 1	ime, data and place, end	due to th	e cause(a) a	forth Day Year)	
BE	4 Homicide 29a. CERTIFIER (Check only one) 2 MEDI	FYING PHYSI						leath occur	ed at the 1	ime, data and place, end	due to th	e cause(a) a	forth Day Year)	
	4 Homicide 29a. CERTIFIER (Check only one) 2 MEDI	OF CERTIFIES	COMPLETED CAUS	les /	and/or Inves	etigation, in m		leath occur	ed at the 1	ime, data and place, end	due to th	e cause(a) a	forth Day Year)	
BE	4 Homicide 29a. CERTIFIER (Check only one) 2 MEDI 29b. SIGNATURE AND TITLE	OF CERTIFIES	Con the basis of as	les /	and/or Inves	otigetion, in my		leath occur	ed at the 1	ime, data and place, end	due to th	e cause(a) a	forth Day Year)	
BE	4 Homicide 29a. CERTIFIER (Check only one) 2 MEDI 29b. SIGNATURE AND TITLE	CAL EXAMINE OF CERTIFIES PERSON WHI	COMPLETED CAUSE	SE OF DEAT	TH (ITEM 27	etigation, in m		leath occur	ed at the 1	ime, data and place, end	due to th	e cause(a) a		
BE	298. CERTIFIER (Check only one) 2 MEDI 290. SIGNATURE AND TITLE 30. NAME AND ADDRESS OF	CAL EXAMINE OF CERTIFIES PERSON WHI	COMPLETED CAUSE	SE OF DEAT	TH (ITEM 27	otigetion, in my		leath occur	ed at the 1	ime, data and place, end	due to th	e cause(a) a	footh Day Year)	

the state of the s

	FOR STATE REGISTRAR	STATE OF MARYLA	ND / DEPAR				MENTAL HYGIEN	_			
	1. DECEDENT'S NAME (First, Middle, Last)						2 DATE OF DEATH		T	3. TIME OF DEATH	
	GLORIA ANN		мск	ENNA			DECEMBER DECEMBER	2, 19	95	4:02 A M	
	4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE (II	yrs. last birthday)	IF UNDER 1		F UNDER 24 HRS.	7. DATE OF BIRTH		BIRTH	PLACE (State or Foreign	
	080 16 0303		74 YRS.			IOURS MIN.	(Month, Day, Year) Oct. 22,19			York	
œ	9a. FACILITY NAME (If not institution, give s THE JOHNS HOPKIN					LOCATION OF DE	EATH	9c. COUNT		EATH	
DIRECTOR	RESIDENCE OF DECEDENT	19 HOSELIAL		DAL.	TITIOI	CE OILI		N/	A		
<u> </u>	10a. STATE 10b. COUNT	γ	10c. CIT	Y, TOWN OF	R LOCATIO	N				10d. INSIDE CITY LIMITS?	
	Maryland Anne	Arundel	Cr	oftor	n					1 TES AND	
A	10e. STREET AND NUMBER				101. Z	IP CODE		10g. CITIZE	N OF W	HAT COUNTRY?	
E I	1606 Eton Way				2	1114		Unit	ited States		
FUNERAL	11. MARITAL STATUS	12. WAS DECEDENT EVER IN FORCES? 1 YES	U.S. ARMED				NIC ORIGIN? (Specify Year, Puerto Rican, atc.)	or No- 1	4. RACE Black	- American Indian, White, etc.	
BY	1 Never Married 2 X Married 3 Widowed 4 Divorced	IF YES, GIVE WAR OR DA	NO.			NO Specify	y:	- 6	Spech	fy:	
	15. DECEDENT'S EDU	CATION	16a. DECEDENT'S	USUAL OC	CUPATION		NO 16b, KIND OF BU	SINESS/INDII	STRY	White	
	(Specify only highest grade Elementary/Secondary (0-12)		(Give kind of tife. Do NOT us	work done di	luring most	of working	NO. KIND OF BO	31NE 33/1100	31111		
3	Elementary/Secondary (0-12)	∠ (1-4 or 5+)	Socia	1 Wor	rkar		County	Corre	rnm	ent	
COMPLETED	17. FATHER'S NAME (First, Middle, Last)		DOCIO	1 1101		IS. MOTHER'S NA	ME (First, Middle, Malden		LIIII	ent	
BE C	Michael Acerno					Marga	ret McGuin	ness			
	19s. INFORMANT'S NAME (Type/Print)		19b. MAILING	ADDRESS	(Street and		Route Number, City or Tow		ode)		
2	John P. McKenna		1606	Etor	n Way	Crofto	n Maryland	1 2111	4	filled meets	
	20s, METHOD OF DISPOSITION 14-Paurial 2 Cremation 3 Rem	ovat from Stata com	PLACE AND DATE		TION (Name	ol	DATE 20c. LO	CATION — CI	ty or To	wn, State	
- 1	4 Donation 5 Dother (Specify)	Ou		Of Th	e Fi	elds Ce	metery 12/	6/95 1	4il1	ersville Md	
	21. SIONATURE OF FUNERAL SERVICE LI	CENSEE				ADDRESS OF FA	ans Funera	1 Home	. 10		
	NOWU C.	Chans	Mes				lis Rd. Bo				
\neg	23. PART I. Enter the diseases, or	complications that caused List only one cause on ea	the deeth. Do	not anter t	the mode	of dying, suc	h as cardiac or resp	Iratory arre	st,	Approximate	
	IMMEDIATE CAUSE (Final	Clar Only Die cades on st	,							Onaet and Death	
	disesse or condition resulting in death)		>cDS	15						Week	
	DUE TO (OR AN A COMSEQUENCE OF):								2 . 1		
N	Sequentially list conditions,	· Ca	10,000	DISECUENCE OF:						Sweeks	
Ā	Sequentistic list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE. Other UNDERLYING CAUSE (Disease or Injury)									Burner	
임	CAUSE (Disease or Injury that infiltsted events Due to (dr As A CONSEQUENCE OF)									2 of Cock	
CERTIFICATION	resulting in desth) LAST	Ag.				/					
¥	PART II. Other significent condition		_			ceuse given in	Pert I. 24s. WAS AN PERFO		24b.	. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO	
MEDIC	A. (1			simo	9		t 🗆 YES :	NO		OF DEATH?	
M		foctic Anun			10 🗖			·		1 YES 2 NO	
AN	DID TOBACCO USE CONT		26. PLACE OF DEA	ES N		UNCERTAI	N LK				
PHYSICIAN:	EXAMINER?	HOSPITAL:		OTHER	1:	- 67 - 57 - 57					
¥	27. MANNER OF DEATH	1 Inpatient 2 ER/Outp	28b. TIR		28c. INJUF		8 Other (Specify) 28d. DESCRIBE HOW	INJURY OCCI	IRED		
	1 Natural 5 Pending	(Month, Day, Year)		JURY	WORK						
ВУ	2 Accident Investigation 3 Suicide a Could not be	28a. PLACE OF INJURY	- At home, farm,	atreat, facto	ory, office		281. LOCATION (Street		r Rural F	loute Number,	
COMPLETED	4 Homicide determined	building, etc. (Spec	ny)				City or Town, State)			
7	290. CERTIFIER 1 CERTIFYING PHYS	IICIAN: To the best of my knowl	edge, death occur	ed at the til	me, date ei	nd piece, and due	to the couse(e) and me	nner es state	1		
N N	0.001	ER: On the basic of examination) end manner as stated.	
	296. SIGNATURE AND TITLE OF CERTIFIE	R	. ^			29c. LICENSE NU	MBER	29d. OATE	SIGNED	(Month, Day, Year)	
BE	5-21		ant Re	dent		L 9768	-	1	1	a 2, 1995	
2	30. NAME AND ADDRESS OF PERSON WI								Crny	(4, 150)	
	S. NAUAR	Town 110 Jo	hns Hop	Kinst	Tospi	Tal Be	altimore 1	n)			
	31. DATE FILED (Month, Day, Year)	32. HEGISTRAP'S SICH									
	DEC 8 1995	Jun									

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OR ATTENDING PHYSICIAM: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	JIRECTORS. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should	JA W	iem 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
IE HOSPITAL OR ATTENDING PI	IE FUNERAL OIRECTOR: After th	filed within 72 hours after death w	PORTANT: If Item 28 is mark
TO T	TO TH	be file	IMPC

	500								9.))0404	,
	1 - STATE REGISTRAR	STATE OF M	MARYLAND / CE		TMENT OF I			L HYGIEN REG. NO		2 <u>U</u>		
	1. DECEDENT'S NAME (First, Middle, Last,)						OF DEATH	AY 100	YEAR	3. TIME OF DEATI	н
	TERRENCE	Α.		Mo	cKOY		NOV	NOV. 27 DAY 1995 6.2				рм
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. last	t birthday)	IF UNDER 1 YEAR	IF UNDER 24 H	15.6	OF BIRTH		8. BIRTHE	PLACE (State or For	reign
	215-19-1277	1X M 2 F	19	YRS.	MONTHS DAYS	HOURS M	Mar.		1976			VA
	8s. FACILITY NAME (If not institution, give	street end number)			9b. CITY, TOWN	OR LOCATION C				ITY OF DE		VA
DIRECTOR	JOHNS HOPKINS	HOSPITA			BALT	TIMORE	3		Tod n	- 0	84.00	
REC	10e. STATE 10b. COUN			10c. CIT	Y, TOWN OR LOCA	TION		10d. INSIOE CIT LIMITS?				
1		nce Georg	e's		Camp Sp	rings					1 X YES 2	NO
A	10e. STREET AND NUMBER				10	I. ZIP CODE			10g. CITIZ	ZEN OF W	HAT COUNTRY?	
FUNERAL	6807 Westcheste	er Court				20748	8		Un	ited	States	
5	11. MARITAL STATUS		IT EVER IN U.S. ARI			CENDENT OF HI			or No-	14. RACE	- American India, White, etc.	ın,
BY	1 Never Married 2 Merried 3 Widowed 4 Divorced	IF YES, GIVE V		Ю		s 2 XNO S		Hican, etc.)		Specif	Africar rican	a
8	15. DECEDENT'S ED (Specify only highest grad	UCATION	16a, DE	CEDENT'S	USUAL OCCUPATI	ON ont of working	180	. KIND OF BU	SINESS/IND	USTRY		
回	Elementary/Secondary (0-12)	College (1-4 or 5	life	Do NOT us	se retired.)	ist or working						
립		1		Sti	udent			Pri	vate			
COMPLETED	17. FATHER'S NAME (First, Middle, Last)					18. MOTHER	'S NAME (First,	Middle, Maiden	Sumame)			
EC	Augustus McKoy Wilmarie Williams											
00	19e. INFORMANT'S NAME (Type/Print) 19b. MAILING AGORESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)											
5	Augustus McKoy 6807 Westchester Court, Camp Springs, Mc. 20748										48	
	20e. METHOD OF DISPOSITION				OF DISPOSITION (N		DAT		CATION —			
	1X Buriel 2 Cremation 3 Res	moval from Stata	Cemetery, crei	matory or o	ion Ceme	teru	12/2/9		linto	-		
	21. SIGNATURE OF JUNERAL SERVICE L	JCENSEE	11/03/11	-601		ND ADDRESS O		951 0.	TILLCO	11, 11	ם	
	Don T. S.	towart	TIL		STEWA	RT FUNI	ERAL HO		. Was	hing	ton, D.(C.
	23. PAT I. Enter the diseasee, or	complications the	it caused the de	eth. Do							Approxima	
	ahock, or heart feilure	. List only one cau	use on each line	١.							Onset and	
	disease or condition reaulting in death) a. Gunshut Wound (1) Invaluing and heat DUE TO (OR AS A CONSEQUENCE OF):										500	
CERTIFICATION	Sequentially list conditions, if any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF):											
S	cause, Enter UNDERLYING CAUSE (Disease or Injury	С.										
Ē	thet initiated eventa	OUE TO	(OR AS A CONSEC	DUENCE O	F):							
8	reaulting in deeth) LAST	d										
2	PART II. Other algnificent conditions contributing to death but not resulting in the underlying cause given in Part I, 24s. WAS AN AUTOPSY FINDINGS											
MEDICAL	PART II. Other aignificent condition	zniii contributing to	death but not r	aauiting	in the underlying	g cause give	n in Part I.	24a. WAS AN PERFO		246.	AVAILABLE PRIOR	70
ă	f ———————							1 YES	2 NO		OF DEATH?	AUSE
ME											1 VES 2 N	10
	DID TOBACCO USE CON	TRIBUTE TO CA	USE OF DEA	TH Y	ES NO	UNCER	TAIN 🗆					
Y.	25. WAS CASE REFERRED TO MEDICAL		28. PLAC	E OF DEA	TH (Check only one)						
SIC	EXAMINER?	HOSPITAL:	₽ ER/Outpatient 3	□ DOA	OTHER: 4 Nursing Hor	ne 5 🗆 Reside	ence 8 Oth	er (Specify)				
PHYSICIAN:	27. MANNER OF DEATH	28e. DATE OF	FINJURY	28b. TIM	AE OF 28c. IN	JURY AT		SCRIBE HOW	INJURY OCC	CURED		
	1 Natural 5 Pending	11/27/	95		5H13 1	YES 2 NO	0 C.11	inh	Sha	h	0.0	
В	2 Accident Investigation 3 Suicide 8 Could get by	28e PLACE C	OF INJURY — At ho		street, fectory, offi		7 7 2	CATION (Street	and Number	or Rural F	loute Number	
	3 Suicide 8 Could not be 4 N Homicide determined		etc. (Specify)	tre.				or Town, State		O blo		, X
ш	29e. CERTIFIER						<u> </u>	In B	1. 159	Him	ine I had	
릴	(Check only	SICIAN: To the best of										
COMPLETED	2 MEDICAL EXAMI	NER: On the beele of a	xamination end/or i	investigatio	on, in my opinion,	death occured a	at the time, date	s and place, er	nd due to th	e cause(e)) and menner so st	lated.
	296. SIGNATURE AND TITLE OF CERTIF	IER				29c. LICENSE	E NUMBER		29d. DATI	E SIGNED	(Month, Day, Year)	
BE	Wonald #1	1) right	MD =				C.M.E		► NIC	117 2	8,1995	
2	30. NAME AND ADDRESS OF PERSON W	VHO COMPLETED CAU	SE OF DEATH (ITE	M 27) (7/0/	9 Print)	0.	C.H.L	•	140	/ V . Z	0,1993	

Maryland 21201

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

Theodore King M.D. 111 Penn Street, Baltimore,

31. DATE FILED (Month, Day, Year)

DEC 1995

TED CAUSE OF DEATH (ITEM 27) (Type, Print)

A De manuella side de service de

TO BE COMPLETED BY FUNERAL DIRECTOR

IMMEDIATE CAUSE (Final

Sequentially list conditions,

disease or condition resulting in death)

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	0 THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
THE THE	TO THE	be filed	IMPO

BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

2

	Amended #1, 1		MARYLAND /		MENT	OF H	EALTH	AND I	MENTAL HYGIEN REG. NO	_	95	38	3454
	1. DECEDENT'S NAME (First, Middle, Las.	C MAC	rge Cl:	iffor	d M	alc	rey		2. DATE OF DEATH MONTH DO V 22	199	YEAR 3	1/:4	SP M
	4. SOCIAL SECURITY NUMBER 013-03-2097	5. SEX	6. AGE (In yrs. Ias		IF UNDER 1	DAYS	IF UNDER	24 HRS. MIN.	7. DATE OF BIRTH (Month, Day, War) Feb. 18,	1905	Country)	ell,	or Foreign
	9a. FACILITY NAME (If not Institution, give Holy Cross Hospi						Spr		EATH		ntgom		
	Maryland M			town or Location lver Spring						IOd. INSIDE LIMITS?			
	9117 Sudbury Roa	d				101	2090			10g. CITI	USA	AT COUNTR	177
	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	FORCES?	T EVER IN U.S. AF YES 2 X		11	yes, sp			NIC ORIGIN? (Specify Yearn, Puerto Ricen, etc.)	s or No—	14, RACE - Black, Specify:	- American White, etc. Whit	
	15. DECEDENT'S Et (Specify only highest gra Elementary/Secondary (0-12) 1.2		+) (G	CEDENT'S U live kind of wo Do NOT use	retired.)			ng	166. KIND OF BU			ent	
	17. FATHER'S NAME (First, Middle, Lest) Adolfus Malore	У							ME (First, Middle, Melden Unknown	Surname)			
	Beatrice Elaine	Malorey							Route Number City or Tow lver Sprin			01	
	20a, METNOD OF DISPOSITION 1 XBuriel 2 Cremetion 3 Re 4 Donation 5 Other (Specify)	emoval from State	cometery, cri	AND DATE OF STATE OF	er place!			terv	DATE 20c. LO	Ade			
	21. SIGNATURE OF FUNERAL SERVICE	time			22. N	rane	ND ADDRE	J. (neral	Home	, Inc	
1	23. PART I. Enter the disesses, o shock, or heert fellur							-				Appro	el Bstween

If sny, isading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

DUE TO (OR AS A CONSEQUENCE OF):

DUE TO (OR AS A CONSEQUENCE OF):

DUE TO (OR AS A CONSEQUENCE OF):

1. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1. Other significant conditions contributing to death but not resulting in the underlying cause given in Part II.

1. Other significant conditions contributing to death but not resulting in the underlying cause given in Part II.

DUE TO (OR AS A CONSEQUENCE OF):

DUE TO (OR AS A CONSEQUENCE OF):

holangiocarcinoma

24a. WAS AN AUTOPSY PERFORMED?

1 YES 2 NO 24b. WERE AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION DF CAUSE OF DEATN?

1 YES 2 NO

YES | NO | UNCERTAIN | DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATN (Check only one **EXAMINER?** OTHER: 1 TYES 2 NO Inpetient 2 - ER/Outpetient 3 - DOA 4 Nursing Nome 5 Residence 6 Other (Specify) 27. MANNED OF DEATH 26c. INJURY AT WORK? 26s. DATE OF INJURY 26b. TIME OF INJURY 28d. DESCRIBE NOW INJURY OCCURED 1 Natural Pending investigation 1 YES 2 NO 2 Accident 26s. PLACE OF INJURY — At home, ferm, street, factory, office building, stc. (Specify) 261. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be

29a. CERTIFIER (Check only one)

MEDICAL EXAMINED. On the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated.

one)	2 MEDICAL EXAMINER: On 1	he basis of examination and/or investigation	, in my opinion, death occured at the time, date and place	, and due to the cause(a) and manner as stated.
29b, Sallica	URE AND TITLE OF CERTIFIER	,	29c. LICENSE NUMBER	29d. DATE SIGNED (Mogth, Day, Year)

ann the	mp	D38478	12/6
THE AND ADDRESS OF DEPOSIT HIM COMMISSION OF THE			

To Name and Address of Person who completed cause of Death (ITEM 27) (Type, Print)

LAWRENCE	R. STARIN, ND	2730	WIVERSITY	BLVD.W.	Wheaten.	mi
DATE ER ED (Heath Day Mac)	20 DECICEDADIC CIONATURE		1			

DEC 07 1995 Juli Studier Robert

DEC 0.7 195

4 Nomicide

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and the same that the same

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. 24 hours after death. Page 6 may be retained by the hospital or attending physician. IMPORTANT: if Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 6876

BALTIMORE, MARYLAND 21215-0020

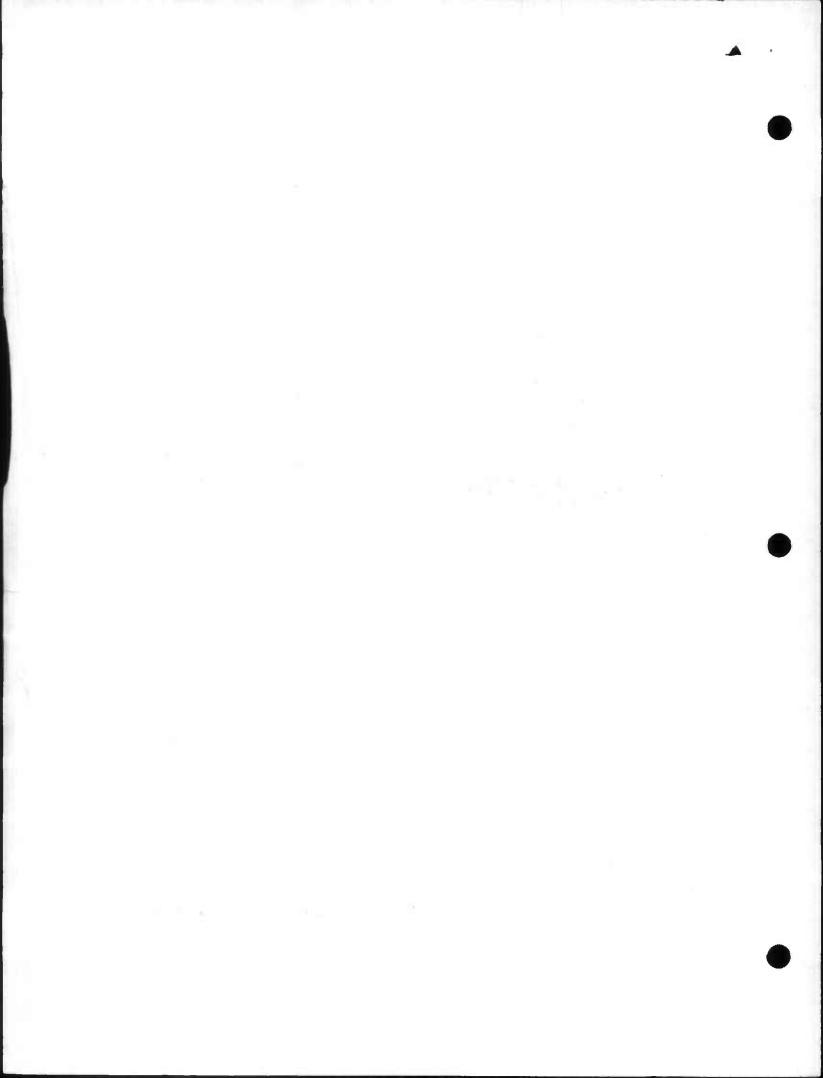
TO BE COMPLETED BY FUNERAL DIRECTOR

ITEMS: 23 PART I, 27, 28a-f, PER MEO FILM G-731 1/3/96 t.t

Amended #9b, 12/8/95, JW, Montgomery County

95 38455

1 · STATE REGISTRAR	SIAIE UF I		RTIF			DEATH	MENIA	REG. NO			
1. DECEDENT'S NAME (First, Middle	a, Last)							OF DEATH			3. TIME OF DEATH
DOUGLAS	R.		MAC	'V			DEC		AY) 2 1	995	9:00 A M
4. SOCIAL SECURITY NUMBER	5. SEX	8. AGE (In yrs. lest			R 1 YEAR	IF UNDER 24 HRS.	7. DATE	OF BIRTH	12 1		PLACE (State or Foreign
217-70-5476	1 反 M 2 🗌 F	36	YRS.	MONTHS	DAYS	HOURS MIN.	(Mont	th, Day, Year)	1050	Countr	nington, DC
9a. FACILITY NAME (If not institution		30		9b. CITY	r. TOWN O	R LOCATION OF D	_	CII 19,	_	NTY OF D	
17541 KOHLHO	SS ROAD						esvi	lle	VA-VA-		MERY
	COUNTY		10c. CITY	, TOWN	OR LOCAT	ION					10d, INSIDE CITY
Maryland	Montgomery			C1	nevv	Chase					LIMITS?
10e. STREET AND NUMBER						ZIP CODE			10g. CIT	IZEN OF W	HAT COUNTRY?
3706 Leland St	reet					20815			Uni	ted S	states
11. MARITAL STATUS 1 Never Married 2 Marrie 3 Wildowed 4XXDivorced	TEVER IN U.S. ARN YES ZYXNO MAR OR DATES		- 1		ENDENT OF HISPA city Cuban, Mexic 2XXNO Speci	an, Puerto		or No—	14. RACE Black Speci	— American Indian, t, White, etc. fy: White	
	'S EDUCATION st grade completed)	16a. DEC	CEDENT'S	USUAL C	CCUPATIO	N st of working	161	b. KIND OF BU	SINESS/IN	DUSTRY	
Elementary/Secondary (0-12)	College (1-4 or 5	life	Do NOT us	e retired.)	curing mos	st or working					
12	_	Au	ito M	lecha	anic			Auto	Repa:	irs	
17. FATHER'S NAME (First, Middle, I	ast)					18. MOTHER'S N	AME (First,	Middle, Maiden	Sumame)		
Raymon	d F. Mack					Bett	y Ha	bes			
19a. INFORMANT'S NAME (Type/Pri	nt)	19b	MAILING	ADDRES	S (Street a	nd Number or Rural	Route Num	nber, City or Tow	rn, State, Zi	p Code)	
Raymond F. Ma	ck	37	706 L	ela	nd St	reet, C	hevy	Chase	, Man	rylan	d 20815
20a. METHOD OF DISPOSITION 1 X Buriel 2 □ Cremetion 3	Ramoval from State			-		me of ember 6,			CATION -	-	
4 Donation 5 Other (Speci		Gate c	of He	avei	n Cen	neterv		ISil	ver s	Sprin	g,Maryland
21. SIGNATURE OF FUNERAL SER	9. Kut	to MC	0348	H	ome/E	Bethesda	-Che	vy Cha	se,	Inc.,	rey Funeral 7557 and 20814
23. PART I. Enter the disease ahock, or heart f IMMEDIATE CAUSE (Final disease or condition resulting in death)	allure. List only one cer	, ALCOHOL A	AND NA	RCOT:				diac or reap	Iratory as	rest,	Approximate Interval Between Onset and Death
	DUE TO	OR AS A CONSEQ	NUENCE OF	7):							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING	DUE TO	(OR AS A CONSEO	UENCE OF	j):							
CAUSE (Disease or Injury that initiated events reaulting in death) LAST	DUE TO	(OR AS A CONSEC	VENCE DF	j):							
	0.										
PART II. Other significent co	nditions contributing to	deeth but not re	esuiting i	n the u	nderlying	ceuae given ir	Pert I.	24a. WAS AN PERFOI 1 YES	RMED?	24b	WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
DID TOP ACCOUNTS	ONITRIDUITE TO CO	LICE OF SEA	TLI VE	<u>- </u>	NO F	LINIOPOTAL		,			YES 2 NO
DID TOBACCO USE C						UNCERTA	IN L				,
25. WAS CASE REFERRED TO MED EXAMINER?	HOSPITAL:		E OF DEAT	OTHE	- / /						
XXVES 2 NO		ER/Outpatient 3		4 🗆 Nu	rsing Hom	e 5 🗆 Residence	7	er (Specify) H		_	FRIEND
1 Netural 5 Pendi	(Month, I	Day, Year)	7:00 7:00	DRY.		RK?		NOWN	INJURY O	CCURED	
3 Suicide 8 XXCould 4 Homicide detarm	not be building	OF INJURY — At hor, atc. (Specify) FOUND	ne, larm, s				281. LO	CATION (Street or Town, State ESVILLE,	1754 MARY	r or Rural P 1 KOHL LAND	Route Number, LHOSS ROAD
	G PHYSICIAN: To the best of a										i) and manner as stated.
296. SIGNATURE AND TITLE OF C	G. King	~~~				O.C.M					(Month, Day, Year) 3, 1995
30. NAME AND ADDRESS OF PER		ISE OF DEATH (ITEM	4 27) (Type,	Print)							
THE WOREN			Pen	n S	tre	et, Ba	ltim	ore,	Mar	ylan	d 21201
DEC 08 199		has significant									
27. MANNER OF DEATH 1	28a. DATE Of (Month, I FOUND: 28a. PLACE (Duilding) 28a. PLACE (Duilding) 28a. PLACE (Duilding) 28a. PLACE (Duilding) 28a. DATE Of (Month, I FOUND: 28a. DATE Of (Month, I FOUND: 28a. DATE Of (Month, I FOUND: 28a. DATE Of (Month, I FOUND: 28a. DATE Of (Month, I FOUND: 28a. DATE Of (Month, I FOUND: 28a. DATE Of (Month, I FOUND: 28a. DATE Of (Month, I FOUND: 28a. DATE Of (Month, I FOUND: 28a. DATE Of (Month, I FOUND: 28a. DATE Of (Month, I FOUND: 28a. DATE Of (Month, I FOUND: 28a. DATE Of (Month, I FOUND: 28a. DATE Of (Month, I FOUND: 28a. DATE Of (Month, I FOUND: 28a. DATE Of (Month, I FOUND: 28a. DATE Of (Month, I FOUND: 28a. PLACE (Duilding) 28a. PLACE	FINJURY Day, Veyar) 12-2-95 12-2-95 DF INJURY — At hor, etc. (Specify) FOUND If my knowledge, day examination and/or is USE OF DEATH (ITER 111 ARYS SIGNATURE	7:00 7:00 me, larm, s the occurrence stigstion M 27) (Type,	AM street, led LLING at the n, in my	28c. INJ WO 1 1 tory, office	URY AT RK? YES 2 XXNO and place, and duesth occured at the 29c. LICENSE NU O . C . M	28d. DE UNK 28f. LO. C/h POOLE te to the core time, det UMBER . E .	SCRIBE HOW NOWN CATION (Street y or Yown, State ESVILLE, ause(a) and ma is and place, as	and Number 1754 MARY	or or Rural / 1 KOHL LAND red. The cause(s) TE SIGNED	HOSS ROAD a) and manner as a (Month, Day, Year) 3,1995



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

ITEMS: 23 PART I, 27, 28a-f, State of Manyland / Department of Health and Mental Hygions.

	PER	MEC	FILM G-731 1/22/96 t.	.t	i y iai ia i	Certificate	of Death)		g. No.	38456
п	Dhysial		1. Decedent's Neme (First, Middle, Las.	t)					ete of Deeth onth		3. Time of Death
ı	Physici /Medi		GEORGE	M		MARSH	ALL		CEMBI		
Si.	Examir		4a. Fecility Neme (If not Institution, give	street end number)		JAIL	4b. City, T	own, or Location	of Death	4c. County of	f Death
			CRISFIELD POLIC	CE DEPART	MENT	CELL	CRIS	FIELD		SOME	RSET
	Funeral Director		212-10-3133		(In yrs. lest bi 22	rthday) If Under 1 Yrs. Months I	Yeer If Unde Deys Hours	7 24 Hrs. 8. De Min. (M	ete of Birth Ionth, Dey,	Yeer)	9. Birthplace (State or Foreign Country) Maryland
	and w		Usuel Residence of Decedent 10e. Stete 10b, County		10c. City, Tow	m or Location					10d. Inside City Limits
020	e Maryli Ba-f sho	Director	Maryland Some			Crisfi	leld				1 M Yes 2 □ No
	th with the 23a or 2		10e. Street end Number 107 Richardson	Ave. / A	pt. C	10f. Zip C	ode 21817		10	g. Citizen of Wi USA	
	72 hours after death with the Maryland natural; or items 23s or 28s-f show deal Experient that he notified at	by Funeral	11. Meritel Stetus 1 Never Merried Married 3 Widowed 4 Divorced	12. Wes Decedent Ev Armed Forces? 1 Yes 2 No If Yes, Give Yeer or Detes:	/er in U,S.	13. Wes Deceder if Yes, specify			es or No- , etc.)	Bieck,	- American Indien, White, etc. White
5-0	72 ho	ted	15. Decedent's Edu (Specify only highest grad	ucation	16a	. Decedent's Usuel (Occupation	et of working	1	6b. Kind of Bus	Iness/Industry
21215-0020	d within jiena. r then	Completed	Elementery/Secondery (0-12) Grade 9	College (1-4or 5+)	(Give kind of work life. DO NOT use Mechani		of of working		Auto	
Maryland	a da de	o Be	17. Father's Neme (First, Middle, Last) G. Morris Mars	shall				er's Neme (Firs.		le <i>ld</i> en Su <i>m</i> eme, er)
any	d 2 should ih and Men 7 is marked traumatic		19e. Informent's Neme/Reletionship (7)	ype, Print)	191	. Melling Address (S	Street end Numi	er or Rural Rou	te Number,		
	TT TT		Beulah M. Wilson	(mother)	28	3134 Vento	on Road	- P.O.B	ox 82		cess Anne,MD 21853
altimore,			20e. Method of Disposition 1	Damanai from State	20b. Piece o	f Disposition (Neme ry, crematory or other	of er plece)	Det	е 2		ity or Town, Stete
Ĕ	Pages ment of I annt: If its ury or or		4 Donetion 5 Other (Specify)		Sunny	ridge Memo	orial Pa	rk 12/1	3/95	Crisf	ield, MD
Bal	permit. Pages Department of Important: If it any Injury or once.		21. Signeture of Funerel Service Licens Robert H. Brads	Sund leve	2	Brads		ons Fun	-	Home eld, MD	21817
	Physician /Medical		23a. Part1. Enter the disease, or comp shock, or heart feilure. List only o	dications thet caused to the cause on each line	he death. Do	not enter the mode	of dying, such e	s cardiec or resp	lretory erre	st,	Approximate Interval Between Onset and Death
1	Examiner		Immediate Ceuse (Finel disease or condition resulting In deeth)	e. HANGING							
		Jer	,	D	ue to (or es a	consequence of):					
oʻ	ficata be axecuted physician and is the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b	ue to (or es e	consequence of);					
x 68760,	certificata b nding physic usa as the bu	Medical	Ceuse (Diseese or injury that Initiated events resulting in death) Lest	d.	ue to (or es e	consequence of):					
Box	ath lite	lan		u.							
P.0.	by the tachex	Physician/M	Pert II. Other significent conditions con	ntributing to death but	not resulting I	n the underlying ceu	se given in Pert	1. 2	t3b. Did tot	1_0	ribute to the cause of death? B Probably 4 Unknown
Records,	sw requires s been sign 2 should be	Completed by						2	4e. Wes an		24b. Were autopsy findings aveileble prior to completion of cause of deeth?
	0 - 0	E							t∕2 Yes	s 2 No	t⊋Yes 2□ No
Vital	iclan: Th cartificate rector, pa	Bec	25. Wes case referred to medical				26. Pled	e of Deeth (Che	ck only one)	/
>	ysicla s cart direct	0	examiner? 1 X Yes 2 No	Hospitel: 1 Inpatient	2 ER/O	utpatient 3 DOA	Other: 4 - N	ursing Home 5	Resider	nce 6 Kother	(Specify) JAIL CEL
on of	Sob	\vdash		One Date of Infrare	28b.	Time of 28c	. injury et Work?	28d. D	escribe hor	w injury occurred	
	ling Ph	\vdash	27. Menner of Deeth 1 Neturel	28a. Dete of Injury (Month, Dey 1 12/8/95	Year) FOU 5:1	8.4	1 ☐ Yes 2) ()	No DE	CEDENT	HANGED HI	d
Division o	tanding Jeath. tor: Afta tha fune	ertification: T	1 □ Neturel 5 □ Pending	12/8/95 28e. Plece of Injury building, etc.	5:1 y - At home, to (Specify)	8.4	1 □ Yes 2) office	28t. Lc	ocation (Straity or Town,		MSELF O'RUCHARDSON AVE.
	Hospital or Attanding 24 hours after death. Funeral Director: After etely filled in by the fune	\vdash	1 Neturel 2 Accident 3(X) Suicide 4 Homicide 5 Pending investigation 6 Could not be determined	12/8/95 28e. Plece of Injury building, etc.	5:1 y - At home, to (Specify) LD POLIC my knowledge exemination en	2 PM arm, street, fectory, of E DEPARTMENT by, deeth occurred et	1 ☐ Yes 2)(0) office the time, dete a	28f. Lo CRIS	ocation (Straity or Town, FIELD, le to the cel	eet end Nymber Stete) 107-C MARYLAND use(s) end mani	MSELF OF FUEL FOUND NUMBER RICHARDSON AVE.
	or Attanding after death. Director: Afta in by tha fune	Certification: T	1 Neturel 2 Accident 3 Suicide 4 Homicide 29e. Certifier (Check only) 2 Medical Exami	12/8/95 28e. Plece of Injury building, etc. CRISFIE sician: To the best of ner: On the basis of e	5:1 y - At home, to (Specify) LD POLIC my knowledge exemination en	2 PM arm, street, fectory, c E DEPARTMENT a, deeth occurred et d/or investigation, in	1 ☐ Yes 2)(0) office the time, dete a	28f. Lo CRIS	ocation (Strity or Town, FIELD, le to the cei he time, da	eet end Number Stete) 107–0 MARYLAND use(s) end mani te end piece, an	MSELF OF FUEL FOUND NUMBER RICHARDSON AVE.

State Registrar

David

31. Dete filed (Month, Day, Year)

DEC 2 1 1995

111 Penn Street, Baltimore, Maryland 21201 32. Pegistrer's Signeture

30. Name end eddress of person who completed ceuse of deeth (Item 23a) (Type, Print)

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DEC 0 4 1995

31. DATE FILED (Month, Day, Year)

TO THE FUNCE/TAIL DR ATTENDING PHYSICIAN: The law requires that the death centhicate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNCE/TOR: After this certificate has been signed by the attending physician and completely filled in by the funcant director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 is the filed within 72 hours after death with the State bett of Hearth and Mental Hygher prior to burial, cermation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH 3. TIME OF DEATH 1995 JEROME REDERICK MANSfield NEABOR 29 12:30 A M 7. DATE OF BIRTH (Month, Day, Year) 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR | IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign HOURS 1X M 2 | F 80 218-09-5855 Aug. 11, 1915 Maryland 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY. TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Fallston General Hospital Harford Fallston 10b. COUNTY 10a. STATE 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY 1 - YES 2 X NO Maryland Fallston Harford FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? 1804 Connolly Road 21047 USA 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENOENT OF HISPANIC ORIGIN? (Specify Year or No-14. RACE — American Indian, Black, White, alc. 1 Never Married 2 Married If yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 YES 2 NO Specify: Specify White BY 3 ₩ Widowed 4 Divorced COMPLETED 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life, Do NOT use retired.) 15. OECEDENT'S EDUCATION (Specify only highest grade complete 16b. KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5+) Rubber Worker Rubber Manufacturing 8 16. MOTHER'S NAME (First, Middle, Malden Surname) 17. FATHER'S NAME (First, Middle, Last) Della (nmn) Broadwater William (nmn) Mansfield BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 1804 Connolly Rd., Fallston, Md. Rebecca M. Ashley 20a, METHOD OF DISPOSITION
1 X Buriel 2 Cremetion 3 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION — City or Town, State 12-1-95 Bel Air, Md. 21014 Bei Air Memorial Grds. 4 Donalion 5 Q Other (Specify) 22. NAME AND ADDRESS OF FACILITY
HOWARD K. McComas III Funeral Home 21. SIGNATURE OF FUNERAL SERVICE LACE 21009 1317 Cokesbury Rd., Abingdon, Md. 23. PART I. Enter the diseases, or compilications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate ahock, or heart failure. List only one cause on each line Onset and Death IMMEDIATE CAUSE (Finel 2 4 Ays disease or condition resulting in death) a RESPIRATORY ACIDOSIS, SEVERE LYPOXEMIA DUE TO EMPHYSEMA CERTIFICATION Sequentially list conditions, c. CONGESTIVE REART PAILURE COR-PULMONALAE
SUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated eventa resulting in desth) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE 24a. WAS AN AUTOPSY PERFORMED? MEDICAL Right upper lobe /UNG CANCER 1 TYES 2 NO DF DEATH? 1 TYES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN X PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one HOSPITAL:
1 Inpatient 2 ER/Outpatient 3 DOA **EXAMINER?** OTHER:
4 | Nursing Home | 5 | Residence | 8 | Other (Specify) 1 YES 2 NO 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED Natural
Accident
Suicide 5 Pending Investigation 1 YES 2 NO BY 28e. PLACE OF INJURY — At home, farm, atreet, factory, office building, etc. (Specify) 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) ETED 6 Could not be 4 Homicide 29s. CERTIFIER
(Check only one)

2 MEDICAL EXAMINER: On the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as attend.

2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as attend. tion and/or investigation, in my opinion, death occurad at the time, dats and place, and due to the cause(s) and manner as stated. 29b. SIGNATURE AND TITLE OF CEROFFER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE D18424

HARFORD ROAD

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FOR 1 - STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAR		CL		CATE OF			REG. NO.			
	1. DECEDENT'S NAME (First, Middle, Last)						2. DATE OF	DEATN		3. TIME OF DEATH	
	OSCAR MONROE MOXLEY December 2, 1995 9:										
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. las		IF UNDER 1 YEAR	IF UNDER 24 HRS,	7, DATE OF			9:00 A M	
					MONTHS DAYS		(Month, E	Dev. Year)	Cour	n(rv)	
	218-18-7867	1 M 2 □ F	83	YRS.			Januai	ry 12,	1917 V	Worth Carolin	
	9a. FACILITY NAME (If not institution, give :	street and number)			9b. CITY, TOWN	OR LOCATION OF	EATH	90	. COUNTY OF	DEATH	
E I	7 Fort Hoyle Road				Joppa				Harfor	rd	
DIRECTOR	RESIDENCE OF DECEDENT	•			OOPPu						
	10a. STATE 10b. COUNT	Υ		10c. CIT	Y, TOWN OR LOC	ATION				10d. INSIDE CITY	
	Maryland Harf	Forci		,To	oppa			LIMITS? 1 YES 2 XNO			
	10e. STREET AND NUMBER	OLG		1 00	A-4-	M TID CODE		10g. CITIZEN OF WHAT COUNTRY?			
3A	100000000000000000000000000000000000000				- 1	101. ZIP CODE					
<u>u</u>	7 Fort Hoyle Road					21085			USA	4	
FUNERAL	11. MARITAL STATUS	12. WAS DECEDEN	T EVER IN U.S. AR		13. WAS DI	ECENDENT OF HISPA	NIC ORIGIN?	ORIGIN? (Specify Yea or No— 14. RACE — American Indian, Black, White, etc.			
	1 Never Married 2 K Married	IF YES, GIVE W		V	1 YE	specify Cuban, Mexic ES 24 NO Spec	mi, Poetto Hic Ny:	an, etc.)		ocity:	
BY	3 Widowed 4 Divorced									White	
ED	15. DECEDENT'S EDU	CATION			USUAL OCCUPAT		18b. K	IND OF BUSINE	SS/INDUSTRY		
E	(Specify only highest grade		Ma	ive kind of a Do NOT us	vork done during r retired.)	nost of working	U	.S. Gov	rernmer	nt	
7	Elementary/Secondary (0-12)	College (1-4 or 5+		roho	ıaaman			epartme			
2			Wa	Tello	useman	_		-		Filmy	
COMPLET	17. FATHER'S NAME (First, Middle, Lest)					18. MOTNER'S N					
BE	John Lester Mox	ley				Ennice	e Vir	glia F	liggins	5	
	19a. INFORMANT'S NAME (Type/Print)		191	b. MAILING	ADDRESS (Stree	t and Number or Rure	Route Number	City or Town, St	tete, Zip Code)		
2	Helen Moxley		7	For	+ Hovle	Road, Jo	oppa. I	Marvlar	nd 210	085	
	20a. METHOD OF DISPOSITION				OF DISPOSITION (DATE				
	1 XBuriel 2 Cremetion 3 Ren	noval from State	cemetery, cre	metory or o	ther place)	Gardens	15				
	4 Donation 8 Other (Specify)		Bel A	ar M				ab per	ALL, I	varytand	
-1	21. SIGNATURE OF FUNERAL SERVICE LI	8771/1			22. NAME	and address of F	Compe	TTT Ehr	aral I	Homo	
	► d/100, Y /	11(1/2000	1011								
	Africa 1.1	11-CON	1000		1 131/	Cokesbu:	rv Ra.	ADIDO	roon . I	Md. 21009	
		annella stiena tha	annual the de	ath Da							
	23. PART I. Enter the discusses, or shock, or heart fellure. IMMEDIATE CAUSE (Finel disease or condition	List only one cau	se on eech line							Approximate interval Between Onset and Death	
	ahock, or heart fellure. IMMEDIATE CAUSE (Finel	List only one cau	t caused the dese on each line	OUENCE O	not enter the n	node of dying, su	ch ss cardle	ic or respirate	ory arrest,	Approximate interval Between Onset and Death	
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2. DATE OF DEATH 1, DECEDENT'S NAME (First) Middle, Last) 3. TIME OF DEATH Martin December 10:52 12995 4. SOCIAL SECURITY NUMBER 5. SEX IF UNDER 1 YEAR 7. DATE OF BIRTH (Month, Day, Year) 8. BIRTHPLACE (State or Foreign Country) 6. AGE (In yrs. lest birthday) IF UNDER 24 HRS. 1 🔀 M 2 🗌 F 212-34-3278 Sept. 5,1937 Maryland permit. Pages 1, 2, 3 should 9s. FACILITY NAME (If not institution, give street and number, 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Bayview Medical Center Baltimore City RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10a, STATE 10d. INSIDE CITY 1 YES 2 | NO Maryland Harford Aberdeen 10e. STREET AND NUMBER FUNERAL 10g. CITIZEN OF WHAT COUNTRY? 10! ZIP CODE funeral director, page 5 should be detached for use as the burial-transit 894 Oxford Avenue 21001 U.S.A. within 24 hours after death. Page 6 may be retained by the hospital or attending physician. 12. WAS DECEDENT EVER IN U.S. ARMED 11. MARITAL STATUS WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-if yes, specify Cuben, Maxicen, Puerto Ricen, etc.) 14. RACE — American Indian, Black, White, atc. FORCES? 1 YES 2 NO 1 Never Married 2 Married 1 YES 2 NO Specify: Specify: BY 3 Widowed 4 Divorced White ETED 15. DECEDENT'S EDUCATION 16s. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working 16b. KIND OF BUSINESS/INDUSTRY (Specify only high (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) COMPL 10 0 Truck Driver Transportation once. 17. FATHER'S NAME (First, Middle Lest) 18. MOTHER'S NAME (First, Middle, Maiden Surname) To Charles W. Martin, Sr. UNK notified 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Charles W. Martin, 894 Oxford Ave., Aberdeen, Maryland 21001 must be 20a. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State 1 N Burial 2 ☐ Cremation 3 ☐ Re Bel Air Memorial Gardens 12/6 Bel Air, Maryland 4 Donation 5 Other (Specify) examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or mart failure. List only one cause on each line. Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399 completely filled in by the medical Approximata Interval Between 6 Onset and Death cremation, or other traumatic event, the QUE TO (OR AS A CONSEQUENCE OF pira VYVOR resulting in death) burial, executed 10000 CERTIFICATION and Sequentially ilst conditions, DUE TO (OR AS & CONSEQUENCE OF) THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death cerunicate be exe THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician at filed within 72 hours after death with the State Dept. of Health and Merital Hygiene prior to I PORTANT: It item 28 is marked, or Item 23 shows any Injury, or other trauma if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disesse or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other aignificent conditions contributing to death but not resulting in the underlying cause given in Part i. 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS MEDICAL Rena ERFORMED? AVAILABLE PRIOR TO transplant COMPLETION OF CAUSE 1 TES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES | NO | UNCERTAIN | PHYSICIAN: 28. PLACE OF DEATH (Check only o 25. WAS CASE REFERRED TO MEDICAL HOSPITAL: EXAMINER? OTHER:
4 | Nursing Home 5 | Residence 8 | Other (Specify) Inpatient 2 - ER/Outpatient 3 - DOA 27. MANNER OF DEATH

1 Netural 5
2 Accident 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 5 Pending Investigation M 1 YES 2 NO BY 28s. PLACE OF INJURY — At home, farm, streat, factory, office building, atc. (Specify) 3 Sulcide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 8 Could not be determined COMPLETED 29a CERTIFIER PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. METICAL EXAMINER: On the be TO THE HOSPITA
TO THE FUNERAL
De filed within 72
IMPORTANT: II als of examination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(s) and manner as ateted. 29h. SIGNATURE AND TITLE OF 29c. LICENSE NUMBER 29d. DATE SIGNED (Mont! Day, Year) BE MI M633. 95 2 30. NAME AND ADDRESS PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 600 N. Wolfe St Cas Gregor L 31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE Julia Davidson Rardall 1994 DHMH-18 Rev 1/89

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

Sec. 1

YEAR

3. TIME OF DEATH

REG. NO.

FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

RECORDS, P.O. BOX 68760 DIVISION OF VITAL

2. DATE OF DEATH DAY NOVEMBER 30,1995 5:17 MAE MURPHY Рм ANNA 4. SOCIAL SECURITY NUMBER 5. SEX 8. AGE (in yrs. last birthday) 7. DATE DF BIRTH (Month, Day, Year) 8. BIRTHPLACE (State or Foreign Country) IF UNDER 1 YEAR IF UNDER 24 HRS. DAYS 1 M 2 X 367-30-3599 AUG.8,1933 OHIO Pages 1, 2, 3 should 9e. FACILITY NAME (If not institution, give street end nu 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY DE DEATH DIRECTOR THE JOHNS HOPKINS HOSPITAL BALTIMORE BALTIMORE CITY 10b. COUNTY toc. CITY, TOWN DR LOCATION 10d. INSIDE CITY MARYLAND TALBOT 1 YES 2 1 ND CORDOVA permit. FUNERAL 10g. CITIZEN DE WHAT COUNTRY? 101. ZIP CODE the burial-transit HARRIS RANGE ROAD 21625 USA 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yee, specify Cuban, Mexicen, Puerto Ricen, etc.)

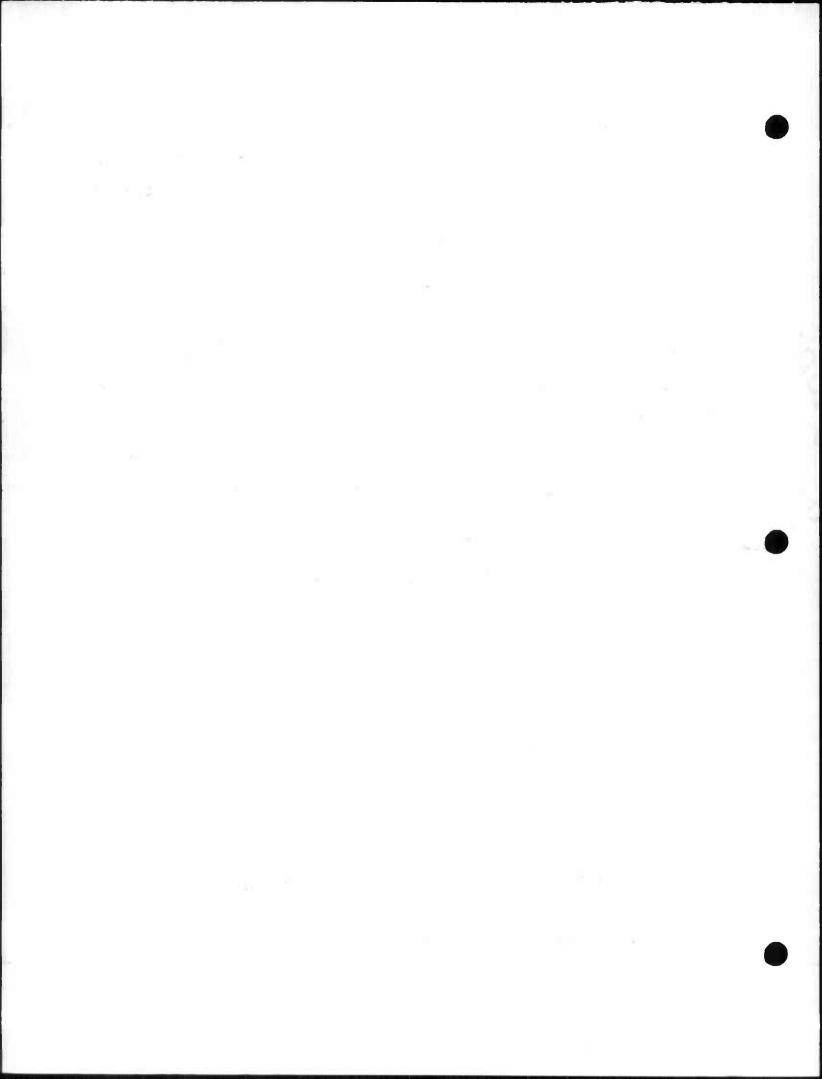
1 YES 2 NO Specify: 11, MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 14. RACE — American Indian, Black, White, etc. FORCES? 1 YES YONO IF YES, GIVE WAR OR DATES 1 Never Married 2 X Merried Specify: WHITE BY 3 Widowed 4 Divorced 98 ETED 15. DECEDENT'S EDUCATION 18e. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY USe (Specify only highest grade completed) ost of working (Give kind of work done life. Do NOT use retired.) 10 Elementary/Secondary (0-12) College (1-4 or 5+) COMPL should be detached 10 COOK RESTAURANT 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) notified at ARTHUR W. HOOVER EUNICE KATHERINE MAYS BE 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street end Number or Rural Route Number, City or To 0 SAMUEL T. MURPHY P.O. BOX 14, CORDOVA, MD 21625 5 page pe 24 METHOD OF DISPOSITION
1 Burtel 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) 20b. PLACE AND DATE DE DISPOSITION /Name of DATE 20c. LOCATION - City or Town, State must director, TILGHMAN CEMETERY TILGHMAN, MD 12 - 3examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE funeral NEWNAM FUNERAL HOME, P.A. HARRISON ST., EASTON, CESP 200 S. filled in by the fion, or removal. HOHN R. MERCERON medical 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. interval Between Onset and Death IMMEDIATE CAUSE (Final SEPSIS traumatic event, the disease or condition 5 DAYS completely reaulting in death) DUE TO (OR AS A CONSEQUENCE OF): burial. 6 DAYS URINAFY TRACT INFECTION DUE TO (OR AS A CONSEQUENCE DF): CERTIFICATION and Sequantially list conditions, prior to If any, leading to immediate cause. Enter UNDERLYING the affending physician Mental Hygiene prior to the death certificate be other t CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF). that initiated events reaulting in death) LAST 6 Injury, PART II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS n signed by t AWAILABLE PRIOR TO RENAL any FAILURE DR ATTENDING PHYSICIAN: The law requires that COMPLETION OF CAUSE 1 YES 2 ND DE DEATH? shows 1 YES 2 ND t. of H DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO W UNCERTAIN PHYSICIAN: has be Dept. 23 26. PLACE OF DEATH (Check only one) 25. WAS CASE REFERRED TO MEDICAL certificate f HOSPITAL: OTHER:
4 | Nursing Home 5 | Residence 6 | Other (Specify) 1 YES 2 NO 1 Impetient 2 - ER/Outpetient 3 - DOA e 16 28b. TIME OF INJURY 27. MANNER OF DEATH 26e. DATE DF INJURY (Month, Day, Year) 28c. INJURY AT WORK?

1 YES 2 NO 28d. DESCRIBE HOW INJURY OCCURED this co marked, 1 Natural 5 Pending Investigation After the ВУ 2 Accident 28e. PLACE OF INJURY — At home, ferm, street, fectory, office building, stc. (Specify) 3 Sulcide 281. LOCATION (Street end Number or Rural Route Number, City or Town, State) 60 6 Could not be ETED. DIRECTOR: A 4 Homicide 28 determined J THE HOSPING.
TO THE FUNERAL DIRE
Be filed within 72 hov Item 29e. CERTIFIER

(Check only

1 DECERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) end manner ee stated. COMPL 2 MEDICAL EXAMINER: On the basis of exemination end/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and menner se stated. 295 SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE The Mcherson M.D. MO244 NOVEMBER30, 1995 9 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) BALT IMDRE, MP JOHN A. MCPHERSON, M.D. GOON. WOLFE ST. TOWER 110. 21287 32, REGISTRAR'S SIGNATURE
Falsa Dawdier Randall 31. DATE FILED (Month, Day, Year) DEC 04 1995 DHMH-18 Rev 1/89

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH



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29b, SIGNATA

OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed written 24 hours after death. Page 6 may be retained	DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should		Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified
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ours afte	d in by t	hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	medica
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FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 -CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH Elsie DAY 11. 18. YEAR en 04 95 am 4. SOCIAL SECURITY NUMBER 7. DATE OF BIRTH 6. AGE (In yrs, last birthday) 8. BIRTHPLACE (State on Foreign IF UNDER 1 YEAR IF UNDER 24 HRS. HOURS 1 M 2 X F 214 - 28 - 9256Virginia Feb 13 Se. FACILITY NAME (If not institution, give street and number, 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Laurel Regional Hospital Laurel Prince George RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Prince George Laurel 1 YES 2 X NO FUNERAL 10e. STREET AND NUMBER 101 ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 14607 Bowie Road 20708 USA 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Merried If yes, specify Cuben, Mexican, Puerto Ricen, etc.) 1 YES 2 NO Specify Specify: ВУ 3 Widowed 4 Divorced White 16e. DECEDENT'S USUAL OCCUPATION

"The kind of work done during most of working COMPLETED 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Spe (Give kind of work done life, Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) Grade 10 School Bus Aide Prince George County 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Surname) Frank Kennan Katie Huff BE 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street end Number or Rural Route Number, City or Town, State, Zip Code) 2 14607 Bowie Road, Laurel, Maryland 20708 Robert J. Miller 20e, METHOD OF DISPOSITION
1 □ Burlel 2 🖔 Cremetion 3 □ Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION -- City or Town, State 4 Donetion 5 Other (Specify) Metro Crematory, Inc. 12/6 | Catonsville, Maryland 21. SIGNATURE OF FUNERAL SERVICE LICENSE 22. NAME AND ADDRESS OF FACILITY Donaldson Funeral Home, P.A. 313 Talbott Ave. Laurel, Maryland 20707 23. PART t. Enter the discussed or complications that caused the desired shock, or hear failure. List only one cause on each line. dications that caused the deeth. Do not enter the moda of dying, such as cerdiac or respiratory errest, Approximate interval Between 2 Monta IMMEDIATE CAUSE (Final disease or condition Kesperaton reaulting in death) DUE TO FOR AS A CONSEQUENCE OF tercutareous festulare CERTIFICATION Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING **CAUSE** (Disease or Injury Syndronie DUE TO (OR AS A CONSEQUENCE OF gut that initiated events resulting in death) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24b. WERE AUTOPSY FINDINGS MEDICAL 24a, WAS AN AUTOPSY AMILABLE PRIOR TO COMPLETION OF CAUSE PERFORMED al nulvi 1 YES 2 NO Surge OF DEATH? aledoninel blog 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: 26. PLACE DF DEATH (Check only one 25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL:
1X Inpatient 2 - ER/Outpatient 3 - DDA OTHER:
4 Nursing Home 5 Residence 8 Other (Specily) 1 TES 2 NO 28d. DESCRIBE HOW INJURY OCCURED

27. MANNER OF DEATH

28e. DATE OF INJURY (Month, Day, Yeer) 28c. INJURY AT WORK?

Natural
Accident 5 Pending Investigation 1 YES 26e. PLACE OF INJURY building, atc. (Special 3 Suicide 6 Could not be 4 Homicide determined

261, LOCATION (Street and Number or Rural Route Number, City or Town, Stafe)

29e. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(e) and memore se stated. (Check only one)

2 MEDICAL EXAMINER: On the beels of exemination end/or investigation, i	n my opinion, death occured at the time, date end pla	ace, end due to the couse(e) end menner es stated
and title of certifier 18 When	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Oay, Year) 12.5.95

2 NO

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30. P	MANE	ND	ADDRESS	OF PERSON	WHO COMPLE	TED CAUSE	OF DEATH	(ITEM 27) (Type, Print)

HABIB	A BHUTTA	14201	Laurel Parle	Drive
31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE			
DEC 0 6 1995	Julia Davidson Rardall			

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TO THE HOSPITAL OF THE FUNERAL DE FILE WITHIN 72 M

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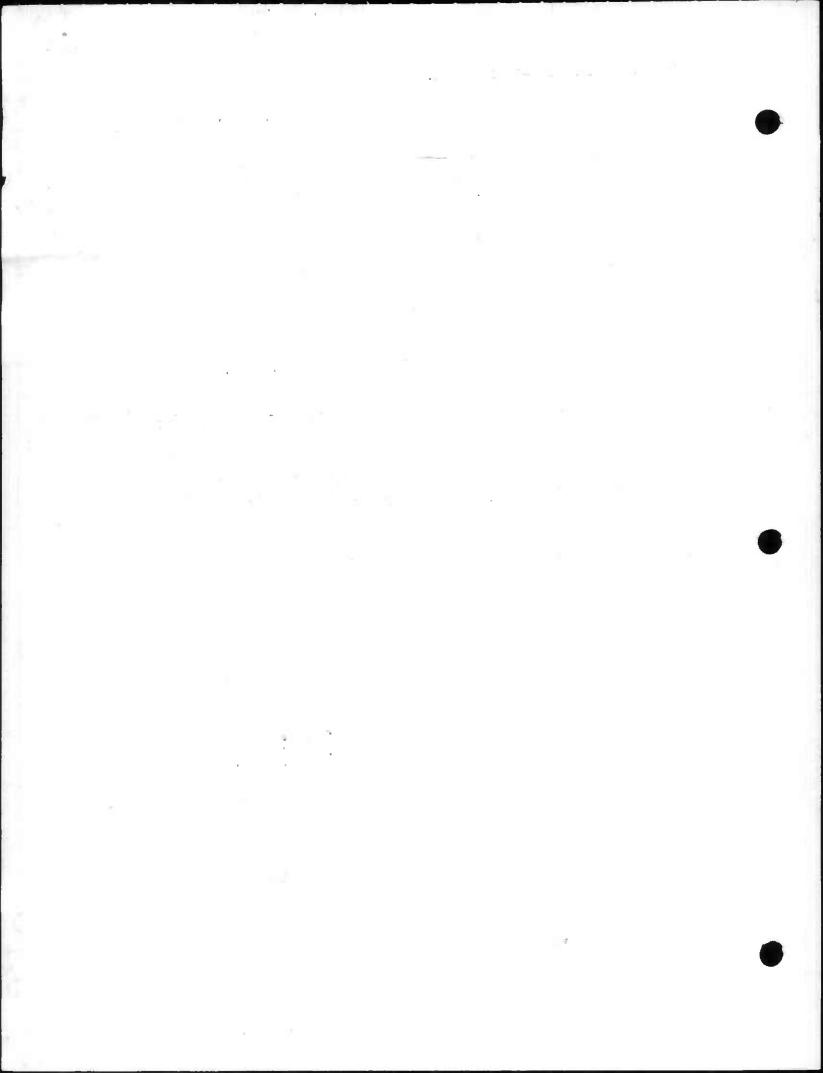
BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

ITEM: 6. PER F.H. FILM G-730 12/20/95 TOTAL DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF OEATH 3. TIME OF DEATH CANO Decembe 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) IF UNDER 24 HRS 7. DATE OF BIRTH (Month, Day, Year) IF UNDER 1 YEAR DAYS 1 M 2 F YRS. DRC-04 45 Pages 1, 2, 3 should and number) 301, Hospital Dr 9b. CITY, TOWN OR LOCATION OF DEATH BC. COUNTY OF DEATH BURNIE DIRECTOR 10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION IOd. INSIDE CITY Maryland Anne Arundel permit. Odenton 1 YES 2XXNO 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10a. CITIZEN OF WHAT COUNTRY? n and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit to burial, cermation, or removal. 2401 G. Forest Edge Court 21113 United States retained by the hospital or attending physician. 12. WAS OECEDENT EVER IN U.S. ARMEO FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No—If yee, specify Cuben, Mexican, Puerto Rican, etc.)

1 YES 2/2/NO Specify: 14. RACE — American Indian, Black, White, etc. 1 Never Married 25 Married BY Specify: 3 Widowed 4 Divorced No White COMPLETED 18e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade Elementary/Secondary (0-12) College (1-4 or 5 +) Homemaker Own Home 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) William F. Ryan Mary Lange BE notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Ibwn, State, Zip Code) 2 Charles T. Miller 2401 G. Forest Edge Court Odenton Maryland 21113 Раде 6 тау be pe 20a. METHOD OF DISPOSITION
1 ☑ Buriel 2 ☐ Cremation 3 ☐ Removal from State 20b. PLACE AND OATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State must Cedar Hill Cemetery

Cedar Hill Cemetery 4 Donetion 5 Other (Specify) 12/14/95 Suitland Maryland examiner 22. NAME AND ADDRESS OF FACILITY 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Rober Robert E. Evans Funeral Home, P.A. trus 16000 Annapolis Rd. Bowie Md. 20715 hours after medicai 23. PART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory erreat, Approximate ehock, or heart fellure. List only one cause on each line. Interval Between IMMEDIATE CAUSE (Finel **Onset and Death** the disease or condition Kenat event. resulting in death) the death certificate be executed traumatic CERTIFICATION cul Sequentially list conditions, if eny, leeding to immediate the attending physician I Mental Hygiene prior to cause. Enter UNDERLYING CAUSE (Disease or Injury other DUE TO (OR AS A CONSEQUENCE OF) thet initiated events resulting in death) LAST 6 PART II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part i. MEDICAL 24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE 24a. WAS AN AUTOPSY Health and N PERFORMEO? any blee-king 1 - YES 2 0 NO OF DEATH? shows 1 YES 2 NO need . DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO 1 UNCERTAIN 1 PHYSICIAN: . OR ATTENDING PHYSICIAN: The law a DIRECTOR: After this certificate has be hours after death with the State Dept. 23 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATH (Check only one) HOSPITAL:
| Inpetient 2 | ER/Outpetient 3 | DOA 1 YES 2 NO OTHER: 4 Nursing Home 5 Residence 6 Other (Specify) 0 26a. OATE DF INJURY (Month, Day, Year) 27. MANNER OF DEATH 28b. TIME OF 28c. INJURY AT WORK? 28d, DESCRIBE HOW INJURY OCCURED 1 Natural М 1 YES 2 NO BY 2 Accident 28e. PLACE OF INJURY — At home, ferm, street, fectory, office building, etc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) .00 ETED 6 Could not be 4 Homicide 28 determined item 29a. CERTIFIER 1 💢 ČERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and menner as stated. COMPL TO THE HOSPITAL O
TO THE FUNERAL DI
DE filed within 72 ho
IMPORTANT: If Ite (Check only one) 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29d. DATE SIGNED (Month, Day, Year) 29c. LICENSE NUMBER BE 4654 Me 5 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 12001 Winday Circle Mohamed S. Mousarell My 31. DATE FILED (Month, Day, Year)
DEC 2 0 1535 32. DEGISTRAR'S SIGNATURE



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DIVISION OF VITAL RECORDS, P.O. BOX 6870

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	after death. Page 6 may be retained by the hospital or a	by the funeral director, page 5 should be detached for us	moval.	ical examiner must be notified at once.
	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	is certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Panes 1.2.3 should	e flied within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	ed, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at ones.
	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law r	TO THE FUNERAL DIRECTOR: After this certificate has be	be filed within 72 hours after death with the State Dept.	IMPORTANT: If Item 28 is marked, or Item 23 s

	1 - STATE REGISTRAR	STATE OF MARYL		IENT OF HEALTH AND ATE OF DEATH	MENTAL HYGIENE REG. NO.						
	1. DECEDENT'S NAME (First, Middle, Last)				2. DATE OF DEATH 3. TIME OF DEAT						
	Dorothy Hobbie No	ewquist			December 6	1:10 p M					
	4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE	In yrs. last birthday)	UNDER 1 YEAR IF UNDER 24 HRS.	7. DATE OF BIRTH	IPLACE (State or Foreign					
	513-01-7735	1 M 2 K F	79 YRS. MO	YTHE DAYS HOURS MIN.	(Month, Day, Year) May 28, 19]	Count	γ)				
	9e. FACILITY NAME (If not institution, give at	reet end number)	98	CITY, TOWN OR LOCATION OF D		9c. COUNTY OF D					
DIRECTOR	Prince George's Hospital Center Cheverly Prince Geo										
RE	10e. STATE 10b. COUNTY		10c. CITY, T	OWN OR LOCATION			10d, INSIDE CITY				
ō	Maryland Princ	e George's	Hyat	tsville		LIMITS? 1 VES 2 NO					
AL	10e. STREET AND NUMBER			101. ZIP CODE		10g. CITIZEN OF V	YHAT COUNTRY?				
FUNERAL	5821 Queens Chape	1 Road		20782		U.S.A.					
Ď.	11. MARITAL STATUS	12. WAS DECEDENT EVER II FORCES? 1 YES		13. WAS DECENDENT OF HISPA	NIC ORIGIN? (Specify Yes o	r No - 14. RACI	- American Indian				
BY 1	1 Never Married 2 Merried 3 Wildowed 4 Divorced	IF YES, OIVE WAR OR D		If yes, specify Cuben, Mexic 1 YES 2 NO Speci		Speci	k, White, etc.				
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COMPLETED	15. DECEDENT'S EDUC (Specify only highest grade	completed)	(Give kind of work	done during most of working	166. KIND OF BUSIN	NESS/INDUSTRY					
) LE	Elementary/Secondary (0-12)	College (1-4 or 5+)	Iffe. Do NOT use re		Magazine						
ME	17. FATHER'S NAME (First, Middle, Last)		Secretary				cal Society				
ၓ	Rudolph Hobbi	0			ME (First, Middle, Maiden Su						
BE	19a. INFORMANT'S NAME (Type/Print)	е	T	Laura	Ehlers						
2	John C. Newquist			DRESS (Street end Number or Rural							
7. III				nbow Drive, Ma							
	20b. PLACE AND DATE OF DISPOSITION 1 N Buried 2 Cremedon 5 Other (Specify) Arlington National Cem. 12/13/95 Arlington, Virginia										
	21. SIGNATURE OF FUNERAL SERVICE LICE	ENSEE A	lington N	22. NAME AND ADDRESS OF FA	/13/95 Arli	ngton, V	ı, Virginia				
	100-0	Francis Gasch's Sons Funeral Home, P.A.									
_	mariles	t. 1see	1	4739 Baltimore	Ave. Hvatt	sville.					
	23. PART I. Enter the diseases, or c	omplications that caused list only one cause on e	the desth. Do not	enter the mode of dying, suc	h ss cardiec or respira	tory arrest,	Approximata				
	IMMEDIATE CAUGE (Final	The state of the s	/	j A	/		Interval Between Oneat and Death				
	disease or condition resulting in death)	Ceres	provasi	rular Acci	dent		30945				
		DUE TO (OR AS A	CONSEQUENCE OF):	1 7	7.						
Z	Sequentially list conditions Due to (or as a consequence of): Property of Disease										
CERTIFICATION	If any, leading to immediate	if any, leading to immediate out to (OR AS A CONSCOUENCE OF):									
2	CAUSE, Disease or Injury Due To (OR AS A CONSEQUENCE OF):										
	that initiated events resulting in death) LAST	DUE TO (OR AS A	CONSEQUENCE OF):								
買		l									
AL	PART II. Other significant conditions contributing to deeth but not resulting in the underlying ceuse given in Pert I. 24a, WAS AN AUTOPSY PINDINGS										
					PERFORM	ED?	AMILABLE PRIOR TO COMPLETION OF CAUSE				
MEDIC					1 TYES 2	INO	OF DEATH?				
2	DID TOBACCO USE CONTR	PIRLITE TO CALISE O	F DEATH VES	T NO D'UNCERTAI			1 TYES 2 THO				
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL		28. PLACE OF DEATH		<u> </u>						
Sic	EXAMINER?	HOSPITAL:	01	HER:							
Ξ	27. MANNER OF DEATH	28e. DATE OF INJURY	28b. TIME OF	Nursing Home 8 Residence	28d, DESCRIBE HOW INJ	Hey Occuped					
	1 Natural S Pending	(Month, Day, Year)	INJURY	M 1 YES 2 NO	TOU. DESCRIBE HOW MY	ONI OCCORED					
B	2 Accident Investigation 3 Suicide & Could not be	28e. PLACE OF INJURY	— At home, term, stree		28t, LOCATION (Street and	1 Number or Burel S	loute Mumber				
	4 Homicide 8 Could not be determined	building, atc. (Spec	ffy)	, , , , , , , , , , , , , , , , , , , ,	City or Town, State)	I NUMBER OF HURSE H	oute Number,				
COMPLETED	290. CERTIFIER				V						
MP				the time, date end place, and due							
႘			end-or investigation, if	my opinion, death occured at the	time, date end place, and o	dun to the ceuse(s	end menner as stated.				
BE	296. SIGNATURE AND THE OF CHATTETER	11	payor	29c LICENSE NUI	ABER 2	9d. DATE SIGNED	(Montel, Day, Year)				
2	20 NAME OF ADDRESS CONTROL	4		1001	100	121	8145				
	30. NAME AND ADDRESS OF PERSON WHO		ATH (ITEM 27) (Type, Prin	1. 5 - 9 .	envicy C	n/r. #	: 430				
	Stuart lurke		7.1).	6-eensel	t rad.						
- 1	31. DATE FILED (Month, Day, Year)	22. RECUETFIANTS SIGN	TURE								
	DEC 8 1995	State Dwell	POL LANGE TO				1				

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MARYLAND 21215-002	r attending
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BALTIMORE	death.
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DIVISION OF VITAL RECORDS, P.O. BOX

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

THE FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. TO BE COMPLETED BY FUNERAL DIRECTOR TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1 - STATE STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.															
1. DECEDENT'S NAME (First, Middle, Last)									2. DATE OF DEATH 3. TIME OF DE					OF DEATH	
THEODORE NEEDEMAN					M				12				4.	25	4 M
4. SOCIAL SECURITY NUMBER		5. SEX		rrs. last birthday)	IF UNDER	YEAR.	IF UNDER	24 HRS.	7. DATE OF (Month, L			6. BIRTI	HPLACE (S	itate or Fore	ign
166 22 4825		1XM 2 F	66	YRS.	2000				Aug.	31,1	929			vania	
9a. FACILITY NAME (If not in		,					OR LOCATI	ON OF D	EATH			NTY OF E			
2916 Traymo		ne			Bow	1e					Pri	nce	Geor	ge's	
10a. STATE	10b. COUNTY	1		10c. CF	TY, TOWN O	R LOCA	TION							IDE CITY	
Maryland	Princ	ce George	e's	В	owie									S 2 N	0
100. STREET AND NUMBER			-			10	1. ZIP COD				10g. CIT	IZEN OF	WHAT COL	JNTRY?	
2916 Trayı	nore La						207					ited	Sta	tes	
11. MARITAL STATUS 1 Never Married 2 🔀	Married	12. WAS DECEDEN	XYES	2 NO					NIC ORIGIN? (en, Puerio Ric		or No-	14. RAC Blac	E — Amer k, White,	ican Indian etc.	•
3 Widowed 4 Divo		1950-1		S	1	_ YES	2 😾 NO	Specif		No		Spec		hite	
15. DEC	EDENT'S EOU	CATION		8a. DECEDENT'S	S USUAL OC	CUPATI	ON			IND OF BU	SINESS/IN	DUSTRY	W	nite	
(Specify online Elementary/Secondary (Control of the Control of th	y highest grade	College (1-4 or 5		(Give kind of life. Do NOT a	work done duse retired.)	uring mo	ost of worki	ng							
12	, ,		'	Typese	etter				Pr	intir	10				
17. FATHER'S NAME (First, M	liddle, Last)	-					18. MOT	HER'S N	AME (First, Mid						
Samue1	Need1	eman					Do	rotl	ny Pas	se					
19a. INFORMANT'S NAME (Type/Print)			19b. MAILIN	G ADDRESS	(Street	and Numbe	r or Aural	Route Number	City or Tow	n, State, Zi	p Code)			
Eleanore	Needle	man		2916	Travi	nore	Lan	e I	Bowie '	Mary]	land	207	15		
20a. METHOD OF DISPOSIT		oval from Stata	20b. Pl	LACE AND OATE	OF DISPOSI	TION (N	ame of		DATE	20c. LO	CATION -	City or T	own, State		
4 Donation 5 Other			Mar	yland	Veter	ans	Ceme	eter	y 12/6	95	Che1t	enha	am Ma	ryla	nd
21. SIGNATURE OF FUNERA	L SERVICE LIE	CENSEE					ND ADDRE		ans Fu	nera	1 Hon	ne 1	ο Δ		
Nowell	J. C.	(van	2	MOD					lis Rd			-		5	
23. PART I. Enter the d		complications the											A	oproximat terval Bet	
IMMEDIATE CAUSE (FI		clar only one ca	Jag OII Gac											nset and	
disease or condition	\rightarrow	ADEN	CAR	CINOHI	4 MET	A57	THIC	.70	LIVE	R			2	HOV	THE
		DUE TO	(OR AS A C	ONSEQUENCE (OF):									Moro	4.0
Sequentially list condit	lona.			10 C		0	C.						6	roun	WJ.
if any, leading to imme cause. Enter UNDERLY	diete	DOE 10	(UH AS A C	ONSEQUENCE	OF):										
CAUSE (Disease or inju		C. DUE TO	(OR AS A C	ONSEQUENCE (OF):								— 		
resulting in death) LAS	т														
		d											-		
PART II. Other algnifica	. ,	- A	death but	not resulting	In the un	derlylr	ng cause	given ir	Part I. 2	4a. WAS AN		24		JTOPSY FINI	
<i>EU</i>	ipuy	SENA	•						_	YES :	2 NO		OF DEAT	TION DF CA 'H?	USE
	/ /												t 🗌 YE	S 2 NO)
DID TOBACCO U		RIBUTE TO CA						CERTA	N X						
25. WAS CASE REFERRED 1 EXAMINER?	TO MEDICAL	HOSPITAL:		. PLACE OF DE	OTHER)			_					
1 YES 2 NO		1 Inpatient 2		lent 3 DOA		_		lasidencs	6 Other	Specify)	IN HERV O	OUIDED			
	Pending		Day, Year)		JURY	W	JURY AT ORK? YES 2	□ NO	280. DE\$C	HIBE HOW	INJUHY OU	COMED			
2 Accident 3 Suicide	Investigation	26a. PLACE	OF INJURY	- At home, farm	atreet, fact			_ 110	281. LOCAT	ION (Street	and Numbi	or Or Rural	Route Nun	nber	
4 Homicide	Could not be detarmined	bullding	atc. (Specify)	,,	.,,				Town, State			110010 11011	,	
29a. CERTIFIER	TIEVING BUYO	ICIAN: To the heart	f mu ka aud	for death		E			4.45				_		
anal .		ER: On the best of											a) and me	Oner ac ata	tad
DATE SIGNATURE ARPLITM	_									in binesit in					.50.
STUMATURE AND THE	J- J	1		MM			296 UC	IN BENE	MHEN			Z -	D (Month,	Day, Year)	
30. NAME AND ADDRESS O	F PERSON W	O COMPLETED CA	ISE OF DEAT	H HTEN TO CT	sa Provi	_	10	170	2		_			/ J	
POBLOT	7) A-	Dagoro	I(M)	. 1430	D GA	115	かて	TOX /	A#	127	Box	116	M.	2071	C .
31. DATE FILED (Month, Day,	Year)	32 AEGISTR			7.11	ا ۳اپ			71	,	-0010	101	.4 6	~ 11	J

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TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the host	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached to the second of	the med within 72 hours are treat with the 23ste copt. Or regard and injury, or other traumatic event, the medical examiner must be notified at once.
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	FOR STATE REGISTRAR	STATE OF MARYL		RTMENT OF		MENTAL HYGIEI REG. NO				
å	1. DECEDENT'S NAME (First, Middle, Last) CHARLES RONAL	LD		Nic	chols	2. DATE OF DEATH Dec. 6	1995 YE	3. TIME OF DEATH 11:35 P M		
	4. SOCIAL SECURITY NUMBER 577-44-8590	1 XM 2 🗆 F 60	in yrs. lest birthday) YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) AUG. 26, 1	935 WA	IRTHPLACE (State or Foreign ountry) SHINGTON, DC		
OR	9e. FACILITY NAME (If not institution, give sti MEMORIAL HOSP)				TON	EATH	9c. COUNTY C	ALBOT		
딥	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY		10c. CI	TY, TOWN OR LOC	ATION			10d. INSIDE CITY		
DIRECTOR	~	EN ANNE		CENTRE	VILLE		1 YES 2 ANO			
Z	100. STREET AND NUMBER				01. ZIP CODE		10g. CITIZEN OF WHAT COUNTRY?			
FUNERAL	125 QUAIL RUN				21617		USA			
BY	11. MARITAL STATUS 1 Never Married 2X Merried 3 Nidowed 4 Divorced	12. WAS DECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR DA	2 X NO	If yea,	ECENDENT OF HISPA specify Cuben, Mexic ES 2X NO Speci	NIC ORIGIN? (Specify Y an, Puerto Rican, etc.) fy:		RACE — American Indian, Black, White, etc. Specify: WHTTE		
ETED	15. DECEDENT'S EDUC (Specify only highest grade Elementary/Secondary (0-12)	CATION completed) College (1-4 pr 5 +)	18e. DECEDENT'S (Give kind of life. Do NOT	S USUAL OCCUPA work done during use retired.)	TION nost of working		USINESS/INDUST			
AP	12	5+	SENIOR	R NUCLI	AR ENGI	NEER C	OMMISS	ION		
COMPLET	17. FATHER'S NAME (First, Middle, Last)					AME (First, Middle, Maide				
BE (ROGER NICHOLS				ANNA	MARIE PE	ILLIPS			
10	190. INFORMANT'S NAME (Type/Print) JEAN MARIE NIC	CHOLS		The second secon		Poute Number, City or R		, MD 21617		
	20s. METHOD OF DISPOSITION 1 Burlel 2 Cremetion 3 Remo	20b	PLACE AND DATE	OF DISPOSITION	Name of	OATE 20c. L	OCATION — City	or Town, State		
	4 Donation 5 Other (Specify)		ALISBUI				LISBUR	CI, MD		
!		MERLERO	a cfs	NEW		RAL HOME				
	23. PART I. Enter the diseases, or o	complications that caused	the deeth. Do							
	ahock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition pauling in death) a. Deval Faulure 5 MMP.									
	DUE TO (OR AS A CONSEQUENCE OF):									
CERTIFICATION	Sequentially list conditions, if any, leading to immediate b. Oue TO (OR AS A CONSQUENCE OF):									
2	CAUSE (Disease or Injury CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF):									
F	that initiated events resulting in deeth) LAST									
	PART II. Other algolficant condition	a contributing to death t	out not resulting	In the underly	ing cause given in	Part I. 24s. WAS	AN AUTOPSY	24b. WERE AUTOPSY FINDINGS		
MEDICAL		_		,			ORMED?	AMILABLE PRIOR TO COMPLETION OF CAUSE		
ED							2 8 NO	OF DEATH?		
Α:	DID TOBACCO USE CONTI	RIBUTE TO CAUSE C	F DEATH Y	ES NO	UNCERTA	N D				
IAN	25. WAS CASE REFERRED TO MEDICAL		26. PLACE OF OE	ATH (Check only o	e)					
Sic	EXAMINER? 1 YES 2 NO	HOSPITAL:	patient 3 DOA	OTHER:	ome 5 🗆 Residence	8 Other (Specify)				
PHYSICIAN:	27. MANNER OF DEATH t Netural 5 Pending	28e. DATE OF INJURY (Month, Day, Year)	28b. TI	JURY	NJURY AT WORK? YES 2 NO	28d. DESCRIBE HOY	V INJURY OCCURE	ED		
ВУ	2 Accident Investigation 3 Suicide 5 Could not be	280. PLACE OF INJURY	— At home, ferm			281. LOCATION (Street		lurel Route Number,		
ETED	4 Homicide determined	building, etc. (Spe	спу)			City or Town, Ste	ro)			
COMPL	(Crieck Orly)	ICIAN: To the best of my know ER: On the beele of examination						use(a) end menner se stated.		
BE C	296. SIGNATURE AND TITLE OF CERTIFIE	R			29c. LICENSE NO		29d. DATE SIG	GNED (Month, Day, Year)		
10	30. NAME AND ADDRESS OF PERSON WH	IO COMPLETED CAUSE OF OR	ATH (ITEM 27) (Typ	oe, Print)	D3988	37	11/-	1-75		
	DAVID SMITH,			D AVE	IUE, EAS	STON, MD	21601			
	31. DATE FILED (Month, Day, Year) DEC 07 1995	32. REGISTRAR'S SIGN								
		(1)								

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BALTIMORE, MARYLAND 21215-0020

FOR STATE REGISTRAR

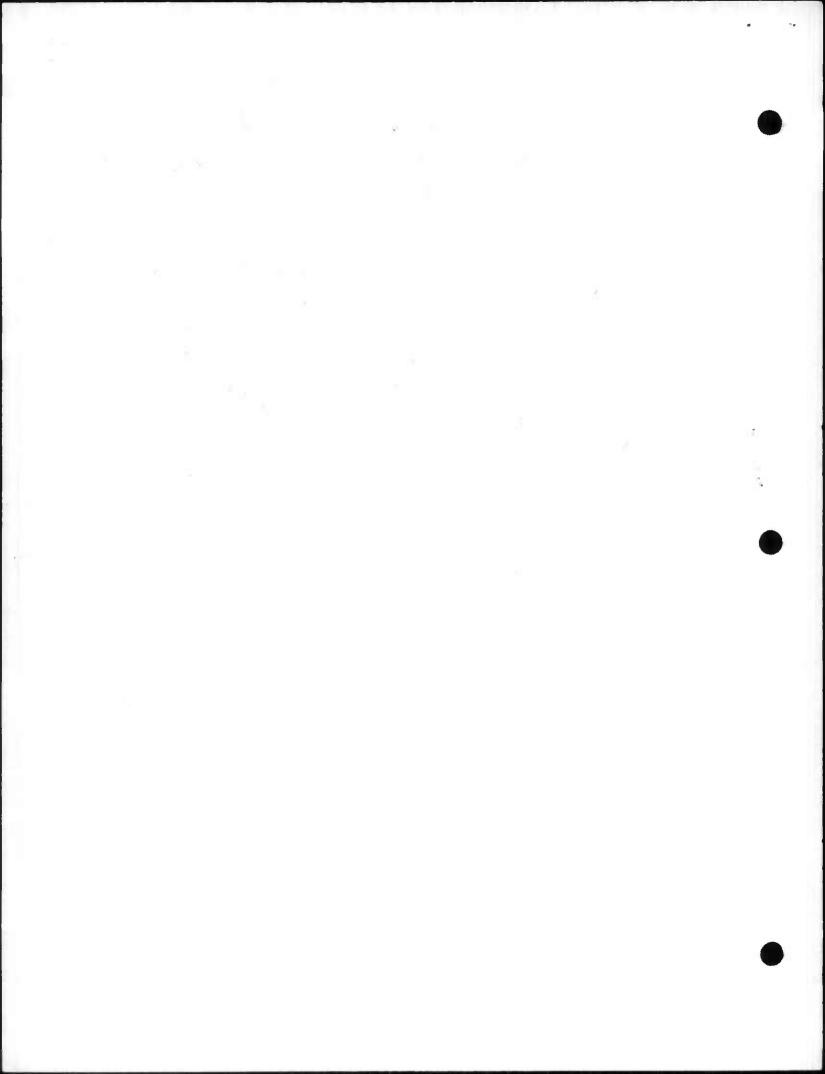
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DIVISION OF VITAL RECORDS, P.O. 1	
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1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH ME 30 MICHAEL NEOZBALA NOVEMBL AM 4. SOCIAL SECURITY NUMBER 6. AGE (in yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year) 1934 130-2 8-368 1 M 2 - F DECEMBER 20 OHI Pages 1, 2, 3 should 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH HOWARD COL DIRECTOR COUNTY GENERAL COLUMBIA HOWARD 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? HOWARD MP COLUMBI, 1 TES 2 NO permit. 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 5384 IRON PEN PLACE completely filled in by the funeral director, page 5 should be detached for use as the burial-transit 21044 Page 6 may, be retained by the hospital or attending physician. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-If yea, specify Cuban, Mexican, Puerto Rican, etc.) RACE — American Indian, Black, White, etc. 1 Never Married 2 Married If yes, specify Cubs BY Specify: 3 Widowed 4 Divorced W COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highe (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) MECH. ENGINEER WESTING-HOUSE + 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, क JAMES NEOZBALA MICHAEL SCHEID BE notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or 2 COLUMBIA - MD 21044 NEOZE 1 RON PEN 90 20a. METHOD OF DISPOSITION
1 Burlal 2 Acremation 3 Removal from State INC NOU 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, Stata must TETRO CREMATORY BALTIMORE 5 Other (Specify) 4 Donation 29 examiner 22. NAME AND ADDRESS OF FACILITY

JOSEPH LICANBY 21. SIGNATURE OF FUNERAL SERVICE LICEN SYKESLILLE within 24 hours after death. w 0 F 567 OEER HILL KOAD MO. 21784 Ener the diseasea, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fellure. List only one cause on each line. medical Approximate Interval Between ŏ IMMEDIATE CAUSE (Final Onset and Death the th cremation, linese or condition ____ HRONIC Renal Mon1 traumatic event, DUE TO (OR AS A CONSEQUENCE OF) Hygiene prior to burial, DUE TO (OR AS A CONSEQUENCE OF) CERTIFICATION and Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury attending physician other t DUE TO (OR AS A CONSPOUENCE OF) that initiated events resulting in death) LAST 6 the atter PART II. Other algoriticent conditions contributing to death but not resulting in the underlying cause given in Part I. 24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE MEDICAL 24a. WAS AN AUTOPSY PERFORMED? Health and PERITONITIS shows any 1 TES 2 NO OF DEATH? 1 YES 2 NO peed 6 DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO 💢 UNCERTAIN 🗆 PHYSICIAN: has b Dept. 23 25. WAS CASE REFERRED TO MEDICAL 28. PLACE QF DEATH (Check only one) State certificate HOSPITAL:
1 Xinpatient 2 - ER/Outpatient 3 - DOA OTHER: 1 | YES 2 | NO 4 □ Nursing Home 5 □ Rasidence 6 □ Other (Specify) 0 ile ile 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 26b. TIME OF 28c. INJURY AT WORK? marked, 28d. DESCRIBE HOW INJURY OCCURED this (1 Natural 5 Pending 1 YES 2 NO M BY Investigation death 2 Accident 28s. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 69 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED DIRECTOR: / 6 Could not be 4 Homicide 28 29a. CERTIFIER

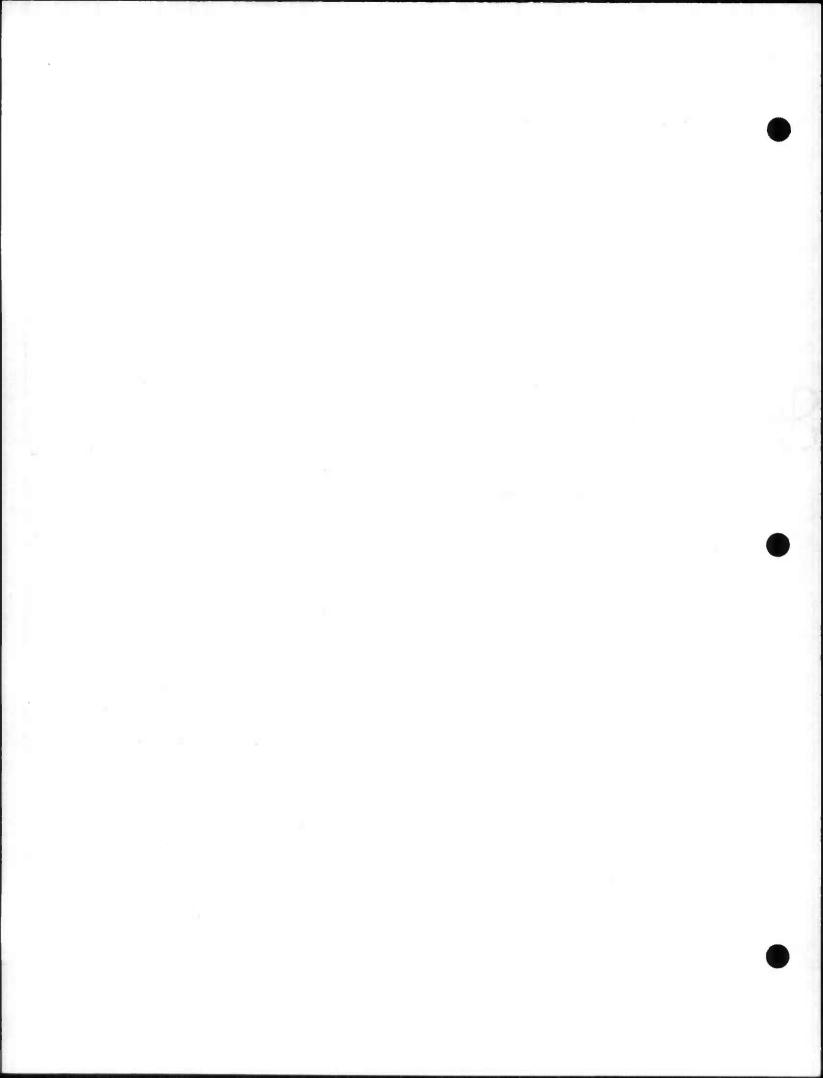
1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. TO THE HOSPITAL TO THE FUNERAL (De filed within 72 h (Check only one) 2 MEDICAL EXAMINER: On the basis of a nination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(e) and manner as stated 296. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE Gremwel 34334 m NOVEMBER 28, 1995 2 PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 30. NAME AND ADDRESS OF Harpers 5999 15 E-110 21044 Columbia mo 31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE NOV 2 9 1995 Julia Davidson Revolate

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH



TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed writinn 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page
be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examinar must be notified at once.

FOR 1 - STATE REGISTRAR	STATE OF MARYL	AND / DEPARTI				IENE . NO.		
1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEA			3. TIME OF DEATN
STEPHEN	J.	0	'CONNE	LL DE	CEMBER	2, 1	1995	12:05 PM
4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE		F UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRT (Month, Day, Y		a. BIRTI	HPLACE (State or Foreign
220-60-3847	1 € M 2 □ F 4:	3 YRS. M	ONTHS DAYS	HOURE MIN.				hington, DC
9e. FACILITY NAME (If not institution, give a	treet end number)	9	b. CITY, TOWN	OR LOCATION OF DE			DUNTY OF	
6036 SOUTHPORT			BETHE			MC	ONTGO	MERY
10e. STATE 10b. COUNTY		100.00	TOWN OR LOCA	TION				10d. INSIDE CITY LIMITS?
	gomery	Bet	hesda					1 TYES 2 NO
10e. STREET AND NUMBER			10	t. ZIP CODE				WHAT COUNTRY?
6036 Southport Dr				20817		Un	ited	States
11. MARITAL STATUS 1 N Never Married 2 Merried 3 Nidowed 4 Divorced	12. WAS DECEDENT EVER I FORCES? 1 YES IF YES, GIVE WAR OR D	2 X NO	It yes, sp	CENDENT OF NISPAN Healty Cuben, Mexice is 2 (X NO Specifi	n, Puerto Ricen, at		14. RAC Blac Spec	E — American Indian, k, White, etc.
15. DECEDENT'S EDUC	CATION	16a. DECEDENT'S US	SUAL OCCUPATI	ON	16b. KIND C	F BUSINESS/	INDUSTRY	777.2.00
(Specify only highest grade	completed)		k done during me		TOOL TOTAL	, boomegan		
Elementery/Secondary (0-12)	College (1-4 or 5 +)	None			N	one		
17. FATHER'S NAME (First, Middle, Last)		None		18. MOTHER'S NA	ME (First, Middle, A		ol .	
Joseph James O'Co	nne11				Joy Kno			
19e. INFORMANT'S NAME (Type/Print)	HILLE	10h MAILING A	DDBESS /Street	and Number or Rural				
Joseph J. O'Con	nell							(D 20852
200. METHOD OF DISPOSITION		b. PLACE AND DATE OF		nor Pl. 4	1	DC. LOCATION		
1 Surial 2 Cremation 3 Rem 4 Donation 5 Other (Specify)	oval trom State Cer	netery, cremetory or othe Gate of He	aven Co	ec. 7, 19 emeterv	995 S	ilver	Sprin	ng. Maryland
21. SIGNATURE OF FUNERAL SERVICE LIC	CENSEE		Robe	ND ADDRESS OF FA	oury nphrev F	uneral	Home	20814-3501
Karl to	ind	M00198	7557	Bethesda-	Chevy C	hase,	Inc.	2001/ 2501
23. PART I. Enter the followsee, or a shock, or heart fellure. IMMEDIATE CAUSE (Final disease or condition reaulting in death)	a. Hyperters	ech line.		otic Co	lidion	and E).e.	Approximete Interval Between Onset and Death
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	c	A CONSEQUENCE OF):						
PART II. Other algolificant condition	e contributing to death i	but not resulting in	the underlyin	g cause given in	P	AS AN AUTOPS ERFORMED? (ES 2 NO	SY 24	MERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? YES 2 NO
DID TOBACCO USE CONT	RIBUTE TO CAUSE O	OF DEATH YES		UNCERTAI	N D			7
25. WAS CASE REFERRED TO MEDICAL		26. PLACE OF DEATH						
EXAMINER? 1X YES 2 NO	HOSPITAL:		OTHER:	ne 8 🗆 Residence	(Special Va	DCVCF	TATI	RIC FACILI
27. MANNER OF DEATN Natural 5 Pending	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME INJUI	OF 28c. IN	JURY AT DRK? YES 2 ND	28d. DESCRIBE			CIO TROIDI
2 Accident Investigation 3 Suicide 8 Could not be detarmined	:0	281. LOCATION (City or Town,		nber or Rural	Route Number,			
29e. CERTIFIER								
(Check only	R: On the basis of my known							e) end menner ee stated.
296. SIGNATURE AND TITLE OF CERTIFIE	R ₁		-	29c. LICENSE NU	MBER	29d, E	DATE SIGNE	D (Month, Day, Year)
Theody 11	Trea .	7				ECEME		3. 1995
30. NAME AND ADDRESS OF PERSON WH	0-11	EATH (ITEM 27) (Type, F	rint)	1 0.C.N	I.D. L	LUEME	DEK .	1990
THE DOOREM.	Keng	111 Peni		et, Bal	Ltimore	, Mai	rylar	nd 21201
31. DATE FILED (Month, Day, Year) DEC 08 1995	Julia Dawolson	Parts 4						



FOR

DIVISION OF VITAL RECORDS, P.O. BOX 68760

24 hours after death. Page 6 may be retained by the hosp	filled in by the funeral director, page 5 should on, or removal.	he medical examiner must be notified a
TO THE HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hosp	TO THE FUNERAL, DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached within 72 hours after death with the State Debri of Health and Mental Hydriene Didor to burial, cremation, or removal.	IMPORTANT. It item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH
REG. NO.

	REGISTRAR CE	RTIF	CATE C	OF DI	EATH	RE	EG. NO.				
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF D			YEAR	3. TIME OF DEA	ГН
	TOTAL C. COMPRIMORY									8:50	AM
	SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 6. BIRT								PLACE (State or Fe	oreign	
	387-05-4679 ¹⅓x ² □ F 78	YRS.	MONTHS DA	WS HO	URS MIN.	OCT. 3		17		ILLINOI	S
	9a. FACILITY NAME (If not institution, give street and number)		9b. CITY, TO	WN OR LO	OCATION OF DE	ATH		9c. COU	NTY OF D	EATH	
DIRECTOR	10206 LARISTON LANE		SILV	ER S	SPRING			MO	NTGO	MERY	
Ä	10a. STATE 10b. COUNTY	10c. CITY	r, TOWN OR LO	OCATION						10d. INSIDE CITY	
	MARYLAND MONTGOMERY	S	ILVER	SPRI	ING					1 - YES 2 X	NO
ME	10e. STREET AND NUMBER			10f. ZIP	CODE			10g. CIT	IZEN OF W	WHAT COUNTRY?	
当	10206 LARISTON LANE			2	20903				UNIT	ED STAT	ES
FUNERAL	11. MARITAL STATUS 1 Never Married 2 Married FORCES? 1 XYES 2 N	MED O			ENT OF HISPAN Cuban, Maxican			or No	14. RACE Black	American Indi Whita, atc.	en,
B	3 Wildowed 4 Divorced IF YES, GIVE WAR OR DATES				NO Specify				Speci		
_	15. DECEDENT'S EDUCATION 16a. DE	CEDENTIE	USUAL OCCUI	DATION		LAGA MINI	0.05.000	INESS/INC	DUATEM	WHITE	
	(Specify only highest grade completed) (Git	ve kind of v	vork done durin	a most of	working	100, KIN	OF BUS	INESS/INL	DUSTRY		
P. E.	Elementary/Secondary (0-12) College (1-4 or 5+) Dep 5+ Educ	artmo	entoof n & We	Hea 1 far	ilth	F	eder	al G	over	nment	
COMPLETED	17. FATHER'S NAME (First, Middle, Last)				MOTHER'S NAI	ME (First, Middle	. Maiden	Surname)			
E O	CHARLES E. OSTERNDORF				MTNNA	ALPERS					
BE		MAILING	ADDRESS (Str	reet and N	lumber or Rural F			n, State, Zip	p Code)		
2	MARY V. OSTERNDORF 10	206	LARIST	ON I	ANE. S	ILVER	SPRI	NG.	MARY	LAND 20	903
	200-PLACE A	ND DATE O	F DISPOSITIO	N (Name o	f	DATE	20c. LO	CATION -	City or To	wn, Stata	
	1 A Surial 2 Cremation 3 Removal from State cemetery, cref	natory or of gton	Natio	nal	Cemete	ry 12-	11-9	5 Ar	ling	ton, V.A.	
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY										
	HINES-RINALDI FUNERAL HOME										
	23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest. Approximate										
	shock, or heert failure. List only one cause on eech line.										atwean
	IMMEDIATE CAUSE (Final disease or condition METACTATIC ADENOCADCINOMA										d Death
	nesulting in death) METASTATIC ADENOCARCINOMA Due to (or as a consequence of):										S.
_											RS.
CERTIFICATION	Sequentially list conditions, if any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF):									32 1	KD.
S	cause. Enter UNDERLYING										
	CAUSE (Disease or injury that initiated events DUE TO (OR AS A CONSEQUENCE OF):										-
	resulting in death) LAST										
0	PART ii. Other significant conditions contributing to death but not re	esulting	n the under	lving ca	use given in	Part i. 24a	WAS AN	AUTOPSY	T 24b	. WERE AUTOPSY F	INDINGS
EDICAL				,	9		PERFOR	MED?		AVAILABLE PRIOR	TO
						— ¹ □	YES 2	A NO		OF DEATH?	
Σ	DID TORACCO LISE CONTRIBILITE TO CALISE OF DEA	TH YE	S \square NO	ו דעו	INICEPTAIN					1 YES 2	NO
PHYSICIAN:	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO X UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one)										
<u> </u>	EXAMINER? 1 YES 2 X NO HOSPITAL: 1 topatient 2 ER/Outpetient 3	_ noa	OTHER:		X Rasidenca	a // aut - //					
H	27. MANNER OF DEATH 28s. DATE OF INJURY	28b, TIM		. INJURY		28d. DESCRIE		NJURY OC	CURED		
	1 Natural 5 Pending (Month, Day, Year)	INJ	URY	WORK?	2 NO						
В	2 Accident Investigation 3 Suicida 8 Could not be 28a. PLACE OF INJURY — At hor building atc. (Specify)	me, farm, a				28f. LOCATIO	N (Street a	and Numbe	r or Rural F	Route Number,	
	4 Homicide datarmined building, atc. (Specify)					City or Tou	wn, State)				
COMPLET	29a. CERTIFIER (Check palv. t CERTIFYING PHYSICIAN: To the best of my knowledge, de	eth occurr	ed at the time	deta and	place and due	to the course(s)	l and man	nas an ele	etad		
Σ	(Check only one) 2 MEDICAL EXAMINER: On the beals of examination and/or i									and manner as	stated.
	29b. SIGNATURE AND TITLE OF COATIFIER				c. LICENSE NUR					(Month, Day, Year)	
R	Koro a alam no					The Paris of the P					
임	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM	4 27) (Type	Print)		D20291			D	EC.	6, 1995	
	ROSS A. ABRAMS, MD 600 North Wo			Ra1	timore	Marv	land	212	87		
	31. DATE FILED (Month, Day, Year) REGISTRANIS SIGNATURE		JELEEL	Jal	LIMOLE	, mary	_4114	- 1 4	V .		
	31. DATE FILED (Month, Day, Year) DEC 07 1995	4									

and the said. The superioris.

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YEAR

95

3. TIME OF DEATN

REG. NO

2. DATE OF DEATH

12

hours after death. Page 6 may be retained by the hospital or attending physician. **MARYLAND 21215-0020** BALTIMORE,

STATE REGISTRAR

Maya Owens

1. DECEDENT'S NAME (First, Middle, Last)

BOX 6876 P.0. RECORDS, DIVISION OF VITAL

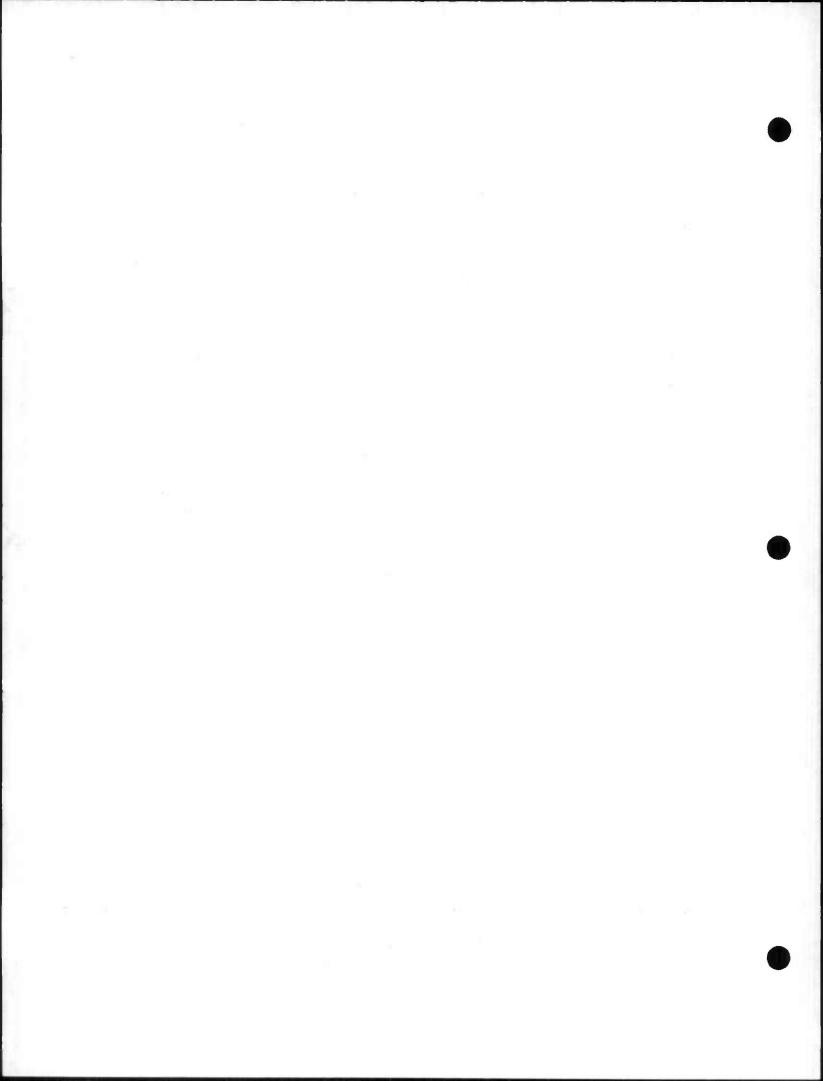
PM 5:00 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In vrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year 8. BIRTHPLACE (State or Foreign Country) 1 🗆 M 2 🙀 F 26 MIN. unknown 0 11-6-95 Maryland Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number) 9c. COUNTY OF DEATH 9b. CITY, TOWN OR LOCATION OF DEATH DIRECTOR Sinai Hospital of Baltimore Baltimore City Baltimore City RESIDENCE OF DECEDENT toa. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Baltimore City Baltimore City 1 VES 2 NO permit. FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE tog. CITIZEN OF WHAT COUNTRY? burial-transit 1937 W. North Ave. U.S.A. 21217 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO II. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-14. RACE — American Indian, Black, White, atc. FUNCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES If yes, specify Cuban, Maxican, Puarto Rican, etc.) 1X Never Married 2 Married 1 TES 2 NO Specify: Specify: Black BY 3 Widowed 4 Divorced use as the COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade comple 16a. DECEDENT'S USUAL OCCUPATION t6b. KIND OF BUSINESS/INDUSTRY (Give kind of work done during most of working life. Do NOT use retired.) detached for Elementary/Secondary (0-12) College (1-4 or 5+) unknown unknown unknown unknown once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) te page 5 should be unknown Monique Nicole Owens BE notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21215 2 Deborah Birckhead Sinai Hospital 2401 W. Belvedere Ave. Balto Md 9 20a. METHOD OF DISPOSITION
1 ☐ Burlal 24X Cremation 3 ☐ Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, Stata DATE must funeral director, Sinai Hospital 4 Donation 5 Other (Specify) 12-95 Baltimore City, Md. medical examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Sinai Hospital of Baltimore Deborah Birckhrad 2401 W. Belvedere Ave. Balto Md 21215 the attending physician and completely filled in by the differential Hygiene prior to build, cremation, or removal. 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, **Approximate** ahock, or haart fallure. List only one cause on each line. interval Between Onset and Death IMMEDIATE CAUSE (Final the disease or condition resulting in death) Necrotizing Enterocolitis 2 days event. DUE TO (OR AS A CONSEQUENCE OF) executed Extreme Prematurity 26 days traumatic CERTIFICATION Sequentially list conditions. DUE TO (OR AS A CONSEQUENCE OF) if any, leading to immediate cause. Enter UNDERLYING HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be Sepsis 2 days CAUSE (Disease or injury or other DUE TO (OR AS A CONSEQUENCE OF): that initiated avents resulting in death) LAST injury, PART II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part i. 24a, WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS MEDICAL AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? signed by the shows any ty YES 2 NO 1 TES 2 NO s certificate has been si th the State Dept. of Hi id, or item 23 show DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN [PHYSICIAN: 26. PLACE OF DEATH (Check only or 25. WAS CASE REFERRED TO MEDICAL HOSPITAL:
1. Unperlient 2 ER/Outpatient 3 DOA **EXAMINER?** OTHER: t TYES 2 NO 4 Nursing Home 5 Residence 6 Other (Specify) 27. MANNER OF DEATH 28a. DATE OF INJURY 28b. TIME OF INJURY 28c. INJURY AT 26d. DESCRIBE HOW INJURY OCCURED this c marked, 5 Pending Investigation 1 X Natural 1 YES 2 NO After ti BY 2 Accident 26a. PLACE OF INJURY — At homa, farm, atreat, factory, offica building, atc. (Specify) 261. LOCATION (Street and Number or Rural Route Number, City or Town, State) 69 3 Sulcida 6 Could not be DIRECTOR: /
hours after d
item 28 is COMPLETED 4 Homicide 29e. CERTIFIER

//Check aniv 1 💢 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(e) and manner as stated. FUNERAL within 72 h = 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and menner as stated. TO THE HOSPITA
TO THE FUNERA
De filed within 72
IMPORTANT: I Mo. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE D-40362 12-4-95 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Pr Thomas P. O'Brien, M.D. Sinai Hospital 2401 W. Belvedere Ave. Balto Md. 32. RESISTRAR'S SIGNATURE 3t. DATE FILED (Month, Day, Year) DEC 2

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

DHMH-16 Rev 1/89



BALTIMORE, MARYLAND 21215-0020
in 24 hours after death. Page 6 may be retained by the hospital or attending physician.
ly filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1. 2. 3 should

FOR 1 . STATE

DIVISION OF VITAL RECORDS, P.O. BOX 68760

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TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hosp	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detache	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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II Q	TO	e fil	MP
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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

	* REGISTRAR		CE	RHE	CALE	F DEAL	п	REG. NO.			
	1. DECEDENT'S NAME (First, Middle, Last)							2. DATE OF DEATH		YEAR	3. TIME OF DEATH
	Sarah A. F	300						11 30		95	23:15 M
			E (in yrs. last	birthday	IF UNDER 1 YE	A IF UNDER	24 HRS.	7. DATE OF BIRTH			IPLACE (State or Foreign
		□ м 2 Қ ∑, ғ			MONTHS DA		MIN.	(Month, Day, Year)		Countr	(Y)
	3//-04-4041	X	94	THS.					901		nington DC
	9e. FACILITY NAME (If not institution, give street	end number)			9b. CITY, TOV	YN OR LOCATIO	ON OF DE	ATH	9c. COU	INTY OF D	EATH
E C	Washington Adventis	t Woonita	1		Tako	ma Par	-k		Mon	tgome	erv
DIRECTOR	RESIDENCE OF DECEDENT	t nospita.	1		1010	7110 101			11011	80111	/
E	10e. STATE 10b. COUNTY	1 -		10c. CITY	TOWN OR LO	CATION					10d. INSIDE CITY
Ë	D. C.	N/A		Wa	shing	on					LIMITS?
											2300
A	10e. STREET AND NUMBER					101. ZIP CODE			10g. Cit		WHAT COUNTRY?
Ш	512 Tuckerman Str	eet, N.	W.			20	0011		_		USA
FUNERAL	11. MARITAL STATUS 12	. WAS DECEDENT EVE	R IN U.S. ARI	WED				IC ORIGIN? (Specify Yes	or No-	14. RACI	E American Indian, k, White, etc.
	1 Never Married 2 Merried	FORCES? 1 YES, GIVE WAR OF	ES 2XXN	0				, Puerto Rican, etc.)			
B∀	1 Never Married 2 Merried 3 Widowed 4 Divorced	IF YES, GIVE WAR OF	HUAIES		1 1	YES 2X NO	Speciny.			BI	ack
	AS DESCRIPTION OF THE PROPERTY	ON:	1 05	00000000				I am white of any		D1107701	
Ш	15. DECEDENT'S EDUCATI (Specify only highest grade corr	ipleted)	188. DE	ve kind of w	ork done during	most of working	g	16b. KIND OF BUS	SINESS/IN	DUSTHY	
ių .	Elementary/Secondary (0-12)	ollege (1-4 or 5 +)	IIIe.	Do NOT use	retired.)						
0	6th		Ho	ousew	ife			N/A			
COMPLETED	17. FATHER'S NAME (First, Middle, Last)			VOLUME	30.0	16. MOTH	IER'S NAM	ME (First, Middle, Meiden	Surname)		
	Dalama Auglani							-			
8	Robert Archer	: :	1					Perry			
5	19e, INFORMANT'S NAME (Type/Print)		19b	. MAILING	ADDRESS (Str	set end Number	or Rural R	loute Number, City or Tow	n, Stete, Zi	p Code)	
F	Robert Page		5	12 Tu	ckerma	n Stre	et N	W Washin	eton	DC	20011
	20e. METHOD OF DISPOSITION				F DISPOSITIO					City or To	
	120 Buriel 2 Cremation 3 Removal	from State	cemetery, crei								
	4 Donation 8 Other (Specify)		Linco	oln M	emori:	1 Ceme	tery	7 12-6 Su	irla	nd l	Md
	21. SIGNATURE OF FUNERAL SERVICE LICENS	SEE			22. NAM	E AND ADDRES	SS OF FAC	Marshal	1's 1	Fune	ral Home Inc
	Par P Ma	chall	2 >					4217 9	th S	Stree	et N. W.,
-								Washing			
	23. PART I. Entar the diseases, or com ahock, or heart fellure. Lief				ot enter the	mode of dyl	ng, suct	n as cardiac or respi	iratory as	rest,	Approximate Interval Between
	IMMEDIATE CAUSE (Finel										Onset and Death
	disease or condition	C	ETPS1	5							6 days
	reaulting in death) a	DUE TO (OR A			2.						/3
		DOE TO (ON A	S A CONSEC	JUENCE OF);						i
Z	Sequentially list conditions, b										
CERTIFICATION	If any, leeding to immediate	DUE TO (OR A	AS A CONSEC	DUENCE OF):						
A	cause. Enter UNDERLYING										
Ĭ	CAUSE (Disease or injury that initiated events	DUE TO (OR A	AS A CONSEC	DUENCE OF	7):						
E	reaulting in death) LAST										
ĬŲ.	d										
	PART II. Other algolificant conditions of	ontributing to deat	h but not r	esulting i	n the under	ving ceuse o	alven In	Part I. 24a. WAS AN	AUTOPSY	241	b. WERE AUTOPSY FINDINGS
EDICAL	RENAL K							PERFOR	1		AVAILABLE PRIOR TO COMPLETION OF CAUSE
š	/CC - G R G /-	7700010	,	1		A		1 TYES 2	NO		OF DEATH?
ME	WAU	ABBURY	mon	<i>/</i> .	3410	onen	تر		/(1 YES 2 NO
	DID TOBACCO USE CONTRIB	UTE TO CAUSE	OF DEA	TH YE	S NO	DX UNC	ERTAIN				
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL	-			H (Check only	/ \					
2	EXAMINER?	OSFITAL:		T	OTHER:						
S	1 TYES 2 NO	Inpatient 2 - ER/C	Outpatient 3	□ DOA	4 - Nursing	Home 5 🗆 Re	sidence	8 Other (Specify)			
Ŧ	27. MANNED OF DEATH	28e. DATE OF INJUI		28b. TIMI	E OF 280 URY	. INJURY AT WORK?		28d. DESCRIBE HOW	NJURY O	COURED	
	1 Natural 5 Pending	(MOTO), Day, 101	ut j	l mo		YES 2	NO				
В	2 Accident Investigation	28e. PLACE OF INJ	URY - At ho	ma ferm s	treet tectory	office		28f. LOCATION (Street	and Numbe	or or Rural	Poute Number
	3 Suicide 8 Could not be 4 Homicide determined	building, atc. (Specify)	,, .	trout, tautory,	011100		City or Town, State)	n or riorer	10010 11011001
ETE	Tomore determined										
T L	290. CERTIFIER 1 CERTIFYING PHYSICIA	N: To the best of my k	nowledge de	eth occum	d at the time	date and place	end due	to the causala) and ma	nner as et	ated.	
ME	(Check only one) 2 MEDICAL EXAMINER:										(a) and manner on stated
COMPL		the come of examini	- non ensurer	v ougano	, my opini	on, water occur		e, sale end prece, er	400 10	e cedad(of sing treatings on materia.
	29b. SIGNATURE AND TITLE OF CERTIFIER	0 0 001 0	000.	A7		29c. LICE	ENSE NUA	ABER A	29d. DA	TE SIGNE	D (Month, Day, Year)
BE	M	Com	Men	-			0) 6	f2518	b /	DEC	01,1995
5	30. NAME AND ADDRESS OF PERSON WHO	OMBI ETED CALLER OF	DEATH ATT	H 270 /5:	(heint)			, ,, ,			vus m
-	A HARD ADDRESS OF PERSON WHO C	OMPLETED CAUSE OF	LIO L	2/) (lype,	erini)	15 P1	KIS	4 2211	R	orko	mus mo
	OUL CHAROK	101, 11	1171			7 1	100	16 216	1		
	31. DATE FILED (Month, Day, Year)	32. PEGIŞTRAR'S S	GNATURE								
	DEC 5 1995	James of the	wher he	Male							

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BALTIMORE, MARYLAND 21215-0020	4 hours after death. Page 6 may be retained by the hospital or attending physician.	certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should ht the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.	ie medical examiner must be notified at once.
DIVISION OF VITAL RECORDS, P.O. BOX 68760	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the fibe within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal,	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1	FOR STATE REGIST
1	. DECEDENT
4	425-8
	e. FACILITY
	6515 RESIDENC
_	Maryla
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,	II. MARITAL S Never M Widowe
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TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	nedio inan				CHILL	ICAL	- 01	DEA	1 6 1		HEG. NO				
	1. DECEDENT'S NAME (First, Mid									2. DATE OF MONTH	D	AY	YEAR	-	E OF DEATH
- 1	Bettye		44							11		0	95		0:00 AM
	4. SOCIAL SECURITY NUMBER 425–88–6137		SEX	6. AGE (In yrs. 1	vest birthday)	IF UNDER	DAYS	HOURS	MIN.	7. DATE OF (Month, I Noven	Jav Vanci	21,	940	Mis	(State or Foreign
- }	9e. FACILITY NAME (If not institut	tion, give street	t and number)			9b. CITY	9b. CITY, TOWN OR LOCATION OF DE			EATH		9c. COU	INTY OF E	DEATH	
m	6515 Hawthor	ne St	reet			T.a	ndo	over			Prince George's		cole		
K I	RESIDENCE OF DECED		1000			100	iido	VCI				1 1 1 1 1	ice (3601	ge s
DIRECTOR		e county Prince	e Georg	e's	10c. CIT	y, town o	ndo							LI	ISIDE CITY MITS? /ES 2 NO
	10e. STREET AND NUMBER				101, ZIP CODE					10g, CIT	IZEN OF	N OF WHAT COUNTRY?			
FUNERAL	6515 Hawthor	ne St	reet						785					S.A.	
E R	11. MARITAL STATUS 1 Never Married 2 Mar 3 Wildowed 4 Divorced	ried	FORCES?	TEVER IN U.S. A I YES 2 S			If yes, sp		n, Mexica	an, Puarto Ric	ORIGIN? (Specify Yee or No— 14. RACE — American Black, White, etc. Specify:				
2		NT'S EDUCAT		16a, I	DECEDENT'S	USUAL O	CCUPATI	DN		18b. N	IND OF BU	SINESS/IN	DUSTRY		
=	(Specify only hig Elementary/Secondary (0-12)	T	mpleted) College (1-4 or 5		(Give kind of life. Do NOT u	work done se retired.)	during m	ost of working	ng						
COMPLETED	12th		Conege (1-4 or 5	+)	(Chef					Pr	ivate	е		
5	17. FATHER'S NAME (First, Middle							18. MOT		AME (First, Mic					
BE	Bob Floyd		is						Li	llie N	1. Ga	rrisc	on		
0	19a, INFORMANT'S NAME (Type/									Route Number				050	
	Roger Pri	.ce			6515	Hawt	hor	ne St	ree	t, Lar	_				
	20a. METHOD DF DISPOSITION 5 Surial 2 Cremation 4 Donation 6 Other (Spe	3 Remove	I from State	camalany	EAND DATE	ther plecal				DATE		CATION -			
	21. SIGNATURE OF FUNERAL SE		ISEE	- LGard	ien Me	emori	AL I	Cemet	Lery	1Z-	1 Ja	CKSO	n, M	1551	ssippi
	Kumbu	ly (Bus	Ical T.	one	-	J. 1	3. Je	enkir	ns Fur	eral	Home	9		20785
CERTIFICATION	Sequentially list conditions if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in desth) LAST	b	DUE TO	O (OR AS A CONS	SEDUENCE D	P):		u ce		4					
E	readiting in death) EAST	d.													
MEDICAL (PART II. Other significant							72.12			248. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO 246. WERE AUTOPSY FIND NAMILABLE PRIOR TO COMPLETION OF CAU DF DEATH? 1 YES 2 NO			BLE PRIOR TO LETION OF CAUSE ATH?	
	DID TOBACCO USE	CONTRI	BUTE TO CA	AUSE OF DE	ATH Y	ES 🗹	NO [JUNG	CERTAI	N					
PHYSICIAN	25. WAS CASE REFERRED TO M EXAMINER? 1 7 TES 2 NO	F	OSPITAL:	26. PL	ACE DF DEA	OTHE	R:	no spr	/	6 Other	041				
<u>"</u>	27, MANNER OF DEATH	- '	26a, DATE O		28b. Til		-	JURY AT	anoenca	_	RIBE HOW	IN HIRV OF	CCUBED		-
	1 Netural 5 Pen			Day, Year)		JURY	W	YES 2 [NO	200. DESC	NIBE HOW	INJUNI O	COMED		
red By	3 Suicide a Cou	etigetion ald not be armined	28s. PLACE building	DF INJURY — At , etc. (Specify)	home, farm,	street, fac	tory, offi	CB .			ION (Street Town, State		er or Rural	Route No	imber,
COMPLETED	CONDUN OTHY		_	of my knowledge, examination and/										(a) and n	nenner as stated.
TO BE C	296. SIGNATURE AND TITLE OF	Y.	Cody	iques 1	m	7		79. LIC	PENSE NU	30		201. DA	TE SIGNE	D (Month.	. Day, Year) 1995
	Augus FOP	Roch	rguet	JE OF DEATH (500	9 Ba	ysu	m(4.9	6 Sm	M	A 2	074	08	
	31. DATE FILED (Month, Day, Year	1995	32. PEGISTR	AR'S SIGNATURE	Carlath	V			,	V			,		

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunal-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH
REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Delzora		OLITTII IT	JAIL U	F DEATH		REG. NO.			
VECZUM	Chapman	Pe	erry		2. DATE MONTH NOVE	mber 2	9, 1	993	3. TIME OF DEATH 12:15P M
4. SOCIAL SECURITY NUMBER 5. SE 237-20-9348 1 □	8. AGE (In		IF UNDER 1 YEAR		7. DATE (Month	Pay Ward	1906	8. BIRTHP	h Carolina
Se. FACILITY NAME (If not institution, give street an	d number)		9b. CITY, TOW	N OR LOCATION OF DE		<u></u>		TY OF DE	
Doctor's Community RESIDENCE OF DECEDENT 100. STATE 100. STATE 100. STREET AND NUMBER 816 Berkshire Drive 11. MARITAL STATUS 12. W				nham					eorges
10a. STATE 10b. COUNTY		10c. CITY,	TOWN OR LO	CATION					10d. INSIDE CITY
Maryland Prince	Georges		Hyatt	sville					LIMITS?
816 Berkshire Drive				101. ZIP CODE 20783					States
	IAS DECEDENT EVER IN U DRCES? 1 YES YES, GIVE WAR OR DATI	2XXNO	If yes,	ECENDENT OF HISPAN specify Cuben, Mexica ES 2XXNO Specifi	n, Puarto R		or No-		- American Indian, White, etc. - Black
15. DECEDENT'S EDUCATION (Specify only highest grade comple Elementary/Secondary (0-12) Colle 12th grade 17. FATNER'S NAME (First, Middle, Last)	ited)	8a. DECEDENT'S U: (Give kind of wo life. Do NOT use	rk done durina	TION most of working	16b.	KIND OF BUS	INESS/IND	USTRY	
Elementary/Secondary (0-12) Colle	ege (1-4 or 5 +)		ewife			Do	omest	·ic	
17. FATNER'S NAME (First, Middle, Last)		11000	CWIIC	18. MOTHER'S NA	ME (First A			.10	
Nathan	Cha	ıpman		Marg		noone, maroerr	surrierrier	P	urvis
190. INFORMANT'S NAME (Type/Print) Thomas Perry, Jr. (son)			e Drive,H					d 20783
20a METHOD OF DISPOSITION 1 M Burlel 2 Cremetion 3 Removal in	20b. P	LACE AND DATE OF	DISPOSITION	(Name of	DATE	20c. LOC	CATION —	City or Tow	n, State
4 ☐ Donation 5 ☐ Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICENSEE		Dancy							North Carol:
I'm Walney	Dineon			Georgia					
23. PART I. Enter the diseases, or complishock, or heart failure. List of IMMEDIATE CAUSE (Final disease or condition resulting in death)	ardia pulm	to nary 2	rest		W - 4 (m)				Approximate Interval Between Onset and Death
Sequentisity list conditions, if sny, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (OR AS A C LIDROTRAM EM DUE TO (OR AS A C DUE TO (OR AS A C OTIC IN SUFFIC	balism, Ronseovence of: whop he bisonseovence of: when cy, A	tis, Con nemia	d Abdomin agastivo Hea	al a	nouri Inne, Ra	yon mlf	ailny	e one week
PART II. Other significant conditions con	tributing to death but	not resulting in	the underly	ing cause given in	Part i.	24a. WAS AN	AUTOPSY	24b.	WERE AUTOPSY FINDINGS
PART II. Other significant conditions con					_	PERFOR	MED?		AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
	TE TO CAUSE OF	DEATH YES	□ NO	☐ UNCERTAI	N 🗆				
25. WAS CASE REFERRED TO MEDICAL EXAMINER?		. PLACE OF DEATH	Check only o	ne)					
1 YES 2 XNO	SPITAL: inpetient 2 - ER/Outpet		OTHER: United States OTHER:	lome 5 🗆 Residence	8 🗆 Other	(Specify)			
1 Natural 5 Pending	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME INJU	RY	INJURY AT WORK?	26d. DES	CRIBE HOW IN	JURY OCC	CURED	
2 Accident Investigation	26s. PLACE OF INJURY — building, atc. (Specify	At home, ferm, str				ATION (Street a or Town, State)	nd Number	or Rural Ro	oute Number,
4 Nomicide determined									
4 Nomicide determined									
29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On 1									and manner as stated.
29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On 1	the basis of exemination a	nd/or investigation	, in my opinio	29c. LICENSE NUI	time, date	and placa, and	29d, DAT	E SIGNED	Month, Day, Year)
4 Nomicide determined 29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On 1 29b. SIGNATURE AND TITLE OF CERTIFIER	PLETED CAUSE OF DEAT	H (ITEM 27) (Type, F	, in my opinio	29c. LICENSE NUI	time, date	and placa, and	29d, DAT	E SIGNED	Month, Day, Year)

what own to ide file of

3. TIME OF DEATN

REG. NO

2. DATE OF DEATH

FOR STATE REGISTRAR

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1. DECEDENT'S NAME (First, Middle, Lest) AURICE 11:15 Am PLE NOU EMBER 1995 5. SEX 7. DATE OF BIRTH (Month, Day, Year 5 -/3 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. lest birthday, IF UNDER 1 YEAR 8. BIRTHPLACE (State or Foreign IF UNDER 24 HRS. WAS HINGTO ND 1 M 2 F YAS 003-22-4928 6 -13permit. Pages 1, 2, 3 should Se. FACILITY NAME (If not institution, give street 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATN AGNES BALTO BALTO HOSP, TAL DIRECTOR RESIDENCE OF DECEDENT 10c, CITY, TOWN OR LOCATION 10e. STATE 10b. COUNTY 10d. INSIDE CITY HOWARD ALTO 1 YES 2 XX FUNERAL 100. STREET AND NUMBER 10f. ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? LUB 615 2/dd funeral director, page 5 should be detached for use as the burial-transit after death. Page 6 may be retained by the hospital or attending physician. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-If yes, specify Cuben, Maxican, Puerto Rican, etc.) 11. MARITAL STATUS 14. RACE — American Indian, Black, White, etc., Specify: Uhite 1 Never Married 2 Marrie 1 YES 2 X NO Specify ΒY 3 Widowed 4 Divorced COMPLETED 16e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specif Elementary/Secondary (0-12) College (1-4 or 5 +) Self Employed 12 Brick Layer once. 17. FATNER'S NAME (First, Middle, Lest) 18. MOTNER'S NAME (First, Middle, Maiden Surname) 70 Edgar M. Pletzer Mary Boucher notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 Helen Pletzer 6154 Hunt Club Road Baltimore, MD 21227 examiner must be 20a. METNOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION --- City or Town, State 1 Burial 2 Cremation 3 Removal from State Meadowridge Cemetery Elkridge, Maryland 11-29 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Harry H. Witzke Funeral Home, Inc. Collino Shew a. 4112 Old Columbia Pike Ellicott City 21043 completely filled in by the other traumatic event, the medical 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximata shock, or haart failure. List only one cause on each line. Interval Between Onset and Death 6 **IMMEDIATE CAUSE (Final** cremation, disease or condition_ METASTATIC ADONO CANCILDINA OF SMALL BOWEL resulting in death) C12161N DUE TO (OR AS A CONSEQUENCE OF). executed burial. CERTIFICATION and Sequantially list conditions, DUE TO (OR AS A CONSEQUENCE OF) the attending physician a Mental Hygiene prior to If any, leading to immediate cause. Enter UNDERLYING 8 certificate CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF). thet initiated events resulting in death) LAST 0 death injury, PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS MEDICAL ap the certificate has been signed by in the State Dept. of Health and AVAILABLE PRIOR TO that 23 shows any FAILURE NEI) MON 1 TYES THO COMPLETION OF CAUSE requires 1 TYES NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐ UNCERTAIN 🛣 PHYSICIAN: 3W 28. PLACE DF DEATN (Check only one) 25. WAS CASE REFERRED TO MEDICAL The Hem HOSPITAL: OTHER: 1 TYES 2 NO PHYSICIAN: 4 Nursing Nome 5 Residence 6 Other (Specify) ŏ 27. MANNER OF DEATN 28a. DATE OF INJURY (Month, Day, Year) 26c. INJURY AT WORK? TIME OF 28d. DESCRIBE NOW INJURY OCCURED marked, this c Natural 5 Pending Investigation 1 YES 2 NO BY After death 2 Accident OR ATTENDING 3 Suicide 28a. PLACE OF INJURY — At homa, larm, streat, factory, office building, atc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) FUNERAL DIRECTOR: At within 72 hours after de RTANT: If Item 28 is .69 8 Could not be COMPLETED 4 Nomicide 29a. CERTIFURG PNYSICIAN: To the best of my knowledge, dasth occurred at the time, data and place, and due to the cause(s) and manner as steted. HOSPITAL TO THE HOSPITA
TO THE FUNERAL
DE filed within 72
IMPORTANT: II 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as steted. 296. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, BE TEH NOUGHBER 96 2 30. NAME AND ADDRESS OF PERSON WNO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 4600 WILHERS AND 31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE 10 ali Davolson Reveall NOV 2 7 1995 **DNMN-16 Rev 1/89**

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

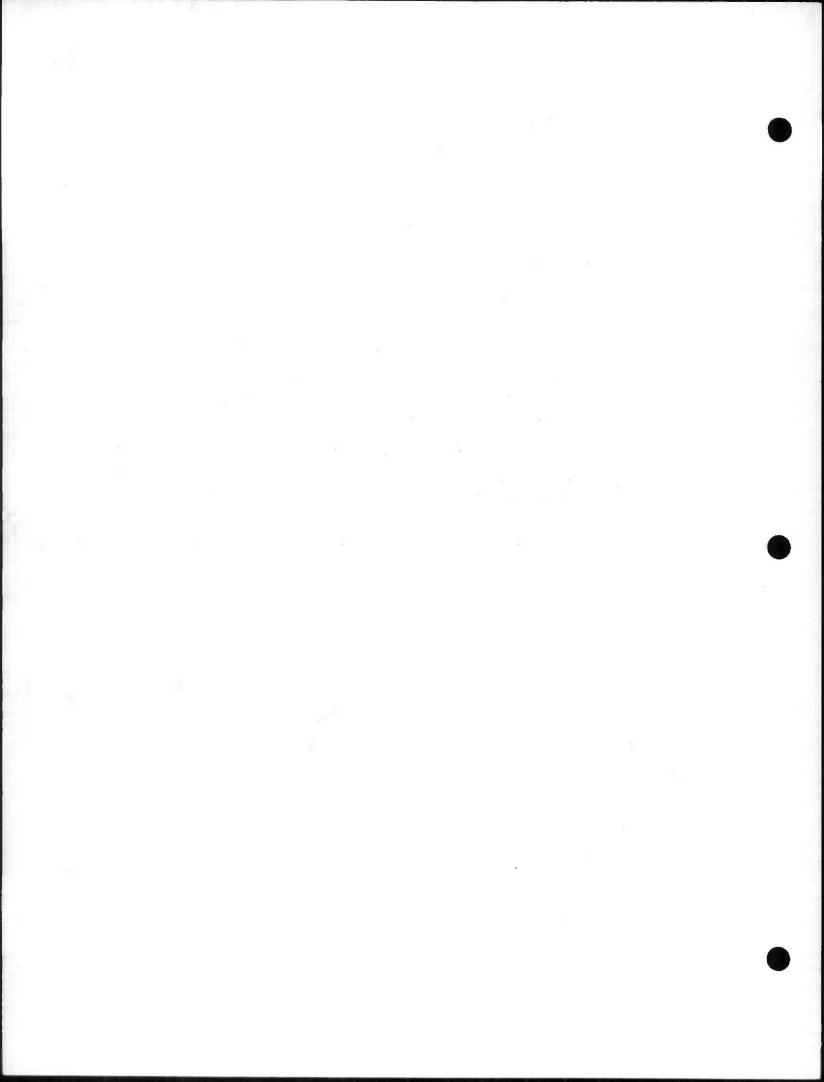
CERTIFICATE OF DEATH

hospital or attending physician. BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 6876

TO THE MOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed without 24 hours after death. Page 6 may be retained by the hospital or attending physician.	this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should	with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	MPORTANT. If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that	TO THE FUNERAL DIRECTOR: After this certificate has been signed by	be filed within 72 hours after death with the State Dept. of Health an	IMPORTANT: If Item 28 is marked, or Item 23 shows any

1 - STATE REGISTRAR				CERTIF	ICALE	UF	DEA	П		REG. NO.				
1. DECEDENT'S NAME (First		Ann S	Shirley	y Pa	age					mber .	ľ, 19	95	3. TIME OF DEATH 8:45A. N	
4. SOCIAL SECURITY NUM 214-34-69		5. SEX 1 M 2 XX	6. AGE (In yrs	s. lest birthday) YRS.	IF UNDER 1	DAYS	IF UNDER	24 HRS.	7, DATE ((Month) Janua	Dey. Year)	1936	936 Washington, D.C.		
90. FACILITY NAME (If not a 5200 Mine							R LOCATI		EATH			nty of D	George's	
nesidence of de	10b. COUNTY	ce George	e's	10c. C11 CO	ry, TOWN OF 11ege	R LOCAT	on ark						16d. INSIDE CITY LIMITS? XX YES 2 \(\square\) NO	
100. STREET AND NUMBER		oad				101	ZIP COD	740					what country?	
11. MARITAL STATUS 1 Never Married 2 3 Widowed 4 Div		12. WAS DECEDEN FORCES? 1 IF YES, GIVE V	YES 2	XNO	11	f yee, sp		ın, Mexica	in, Puerto R	ORIGIN7 (Specify Yes or No— 14. RACE — A Black, Whith Specify:			E — American Indian, k, White, etc.	
	CEDENT'S EDU- nly highest grade (0-12)			(Give kind of life. Do NOT u	work done d ise retired.)	CCUPATIC during mo	ON st of world	ng	16b.	NIND OF BUS		DUSTRY		
17. FATHER'S NAME (First, Charles		9								Middle, Meiden Octor		ļ		
190. INFORMANT'S NAME Anne Mari	e Gard				as #		nd Numbe	r or Rural	Route Numb	er, City or Tow	n, State, Zip	Code)		
20a, METHOD OF DISPOSI 1 X Quriel 2 Cremet 4 Donation 5 Other	er (Specify)			OF HEA	ven Ce	mete	ry 1	2/4/1		Si		prin	g, Maryland	
21. SIGNATURE OF FUNER	AL SERVICE LIC	ENGEE			00.4	MARKE AN	ID ADDRE	SE OF EA	CH PTV					
23 PART L Enter the	dV.	Bogwa	rolt	a death Do	44	400	Powd	ler M	1i11	Rd. Be	eltsv	ille	ne, P.A.	
23. PART I. Enter the shock, or IMMEDIATE CAUSE (F disease or condition resulting in death)	heart fellure.	a. Meta	SAL	e death. Do line.	not anter	the mo	Powd	ler M	fill :	Rd. Be	ratory ar	ille	Approximata Interval Batween	
ahock, or IMMEDIATE CAUSE (F disease or condition	Itiona, ediata YING lury	a. Me Jue To	S A CO	ilne.	not anter	the mo	Powd	ler M	fill :	Rd. Be	ratory ar	ille	Approximata Interval Batween	
ahock, or IMMEDIATE CAUSE (F disease or condition resulting in death) Sequentially list cond If any, leading to imm cause. Enter UNDERL' CAUSE (Disease or in that initieted events	ittlona, ediata ying	a. DUE TO	O (OR AS A CO)	NSEQUENCE C	not anter	400 the mo	Powd	ler M	fill :	Rd. Be	Pltsv Fratory arr	ille	Approximata Interval Batweer Onset and Deat Sincoln Si	
ahock, or IMMEDIATE CAUSE (F disease or condition resulting in death) Sequentially list cond if any, leading to imm cause. Enter UNDERL CAUSE (Disease or in that initieted events resulting in death) LA	itiona, ediata ying structury structury structury uny united to the condition	a. DUE TO C. DUE TO d	O (OR AS A CO) O (OR AS A CO) O (OR AS A CO) O (OR AS A CO)	NSEQUENCE C	DED:	the mo	Powd de of dy	ler M	1111 th sa card	Rd. Bellac or respi	Pltsv Fratory arr	ille	Approximata Interval Batweer Onset and Death Survey	
ahock, or IMMEDIATE CAUSE (F disease or condition resulting in death) Sequentially list cond If any, leading to imm cause. Enter UNDERL CAUSE (Disease or in that initiated events resulting in death) LA PART II. Other algnific DID TOBACCO 25. WAS CASE REFERRED EXAMINER? 1 YES 2 NO	itiona, ediata ying structury structury structury uny united to the condition	b. DUE TO C. DUE TO d. RIBUTE TO CA HOSPITAL: 1 Inpatient 2	O (OR AS A CO) O (OR AS A CO) O (OR AS A CO) O (OR AS A CO) O (OR AS A CO) O (OR AS A CO) O (OR AS A CO) O (OR AS A CO) O (OR AS A CO)	NSEQUENCE CONSEQUE	DF): In the unitary (Check of Almanus)	the mo	Powdde of dy	ler Ming, such Market M	Pert I.	Rd. Beliac or respi	AUTOPSY MED?	ille rest,	Approximate Interval Batweer Onset and Death Simular S	
ahock, or IMMEDIATE CAUSE (F disease or condition resulting in death) Sequentially list cond if any, leading to imm cause. Enter UNDERL CAUSE (Disease or in that initieted events resulting in death) LA PART II. Other algnific DID TOBACCO 25. WAS CASE REFERRED EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Natural 5	itiona, ediata ying structury structury structury uny united to the condition	a. DUE TO b. DUE TO c. DUE TO d. SECONTRIBUTE TO CA HOSPITAL: 1 28e. DATE Of (Month, is	O (OR AS A CO) O (OR	NSEQUENCE CONSEQUE	DF): In the un ATH (Check of Annum Me OF JURY) M GOTHER	the mo	Powod de of dy	der Ming, auc	Pert I. O Othe 28d. DES	Rd. Be	AUTOPSY MED?	24k	Approximate Interval Batweer Onset and Death Simulation of Death Simulation of Completion of Completion of Cause of Death?	
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ahock, or IMMEDIATE CAUSE (F disease or condition resulting in death) Sequentially list cond if any, leading to imm cause. Enter UNDERL CAUSE (Disease or in that initieted events resulting in death) LA PART II, Other aignific DID TOBACCO 25. WAS CASE REFERRED EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Natural 5 2 Accident 3 Suicide 6 4 Homicide	inal itiona, ediata f/ING jury st cent condition To MEDICAL Pending Investigation Could not be determined	BUTE TO CA RIBUTE TO CA MOSPITAL: 1 Inparient 2 28e. DATE Of (Month, i) 28e. PLACE obuilding	OF INJURY — A etc. (Specify)	NSEQUENCE CONSEQUE	AZ not anter OF): In the unitary (Check of ATH (Check of ATH) (C	the mo	Powod de of dy CINO g cause g cause UNC No 5 XR SURY AT DRK? 2 [o end place death occur death occur	given in CERTAI	Pert I. 6 Other 286. LOC. City.	24a. WAS AN PERFOR 1 YES 2 ATION (Street or Town, State)	AUTOPSY MED? AUTOPSY MED? AUTOPSY MACON NUMBER OF MACON NUMB	24k	Approximata Interval Batweet Onset and Deat Should Should Batweet Onset and Deat Should Batweet Deat Shoul	
ahock, or IMMEDIATE CAUSE (F disease or condition resulting in death) Sequentially list cond if any, leading to imm cause. Enter UNDERL CAUSE (Disease or in that initieted events resulting in death) LA PART II, Other aignific DID TOBACCO 25. WAS CASE REFERRED EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Natural 5 2 Accident 3 Suicide 6 4 Homicide	Itiona, ediata ying ury ST Sent condition To MEDICAL Pending investigation Could not be determined ULLY VIND ATTERIOR OF PERSON WE	BUTE TO CA RIBUTE TO CA B. DUE TO C. DUE	OF INJURY — A etc. (Specify)	NSEQUENCE CONSEQUE	AZ not anter OF): In the unitary (Check of ATH (Check of ATH) (C	the mo	Powod de of dy CINO g cause g cause UNC No 5 XR SURY AT DRK? 2 [o end place death occur death occur	given in CERTAL enidence NO	Pert I. 6 Other 286. LOC. City.	24a. WAS AN PERFOR 1 YES 2 ATION (Street or Town, State)	AUTOPSY MED? AUTOPSY MED? AUTOPSY MACON NUMBER OF MACON NUMB	24t CUREO r or Rural ted. the couse(Approximata Interval Batweet Onset and Deat Should Should Batweet Onset and Deat Should Batweet Deat Shoul	



DHMH-18 Rev 1/89

BALTIMORE, MARYLAND 21215-0020

FOR STATE REGISTRAR

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90	MATCHIO
BOX 68760,	ayars start
\tilde{a}	2
.O. B(certificate
a.	death
ö	4
H.	that
RECO	reditines
3	W
A	P
DIVISION OF VITAL RECORDS, P.O. 8	PITAL OR ATTENDING PHYSICIAN: The law remires that the death certificate he executed within 2 hours
VISION	ATTENDING
	a
	PITAL

1. DECEDENT'S NAME (First, Middle, Last) 3 ean 4. SOCIAL SECURITY NUMBER 5. SEX 507-22-6822 1 🗆 M 2XX F filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should ion, or removal. 9a. FACILITY NAME (If not institution, give street and number) 7051 Carroll Avenue DIRECTOR RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY Mary land Montgomery FUNERAL 10e. STREET AND NUMBER 7051 Carroll Avenue after death. Page 6 may be retained by the hospital or attending physician. 11. MARITAL STATUS 12. WAS DECEDENT 1 Never Married 2 Married FORCES? IF YES, OIVE WAS BY 3XXWidowed 4 ☐ Divorced COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade Elementary/Secondary (0-12) College (1-4 or 5+) 12 once. 17. FATHER'S NAME (First, Middle, Last) 7 Hugo John BE notified 19a. INFORMANT'S NAME (Type/Print) 2 Betty M. Lorenzen Pe 20s. METHOD OF DISPOSITION

1 X Burial 2 Cremation 3 Res
4 Donation 8 Other (Specify) must examiner medical 23. PART I. Enter the diseases, or complications that a shock, or heart failure. List only one ceuse 6 **IMMEDIATE CAUSE (Final** signed by the attending physician and completely fille Health and Mental Hygiene prior to burial, cremation, other traumatic event, the disease or condition ante reaulting in death) DUE TO (O CERTIFICATION Sequentially list conditions, DUE TO (O if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (C that initiated events resulting in death) LAST 6 item 23 shows any injury, PART ii. Other significant conditions contributing to de PHYSICIAN: MEDICAL has been of P DID TOBACCO USE CONTRIBUTE TO CAU 25. WAS CASE REFERRED TO MEDICAL the State (EXAMPLER? HOSPITAL: 1 Inpatient 2 E 6 TO THE HOSPITAL OR ATTENDING PHYSICIA
TO THE FUNERAL DIRECTOR: After this centil
be filed within 72 hours after death with the
IMPORTANT: If Item 28 is marked, or 27. MANNER OF DEATH 28a. DATE OF IN 1 Natural BY investigation 2 Accident 28a. PLACE OF 3 Sulcide COMPLETED 8 Could not be 4 Homicide 29a. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of m

MEDICAL EXAMINER: On the beals of examiner

Der

32. REGISTRAR Davo

29b. SIGNATURE AND TITLE OF PERTIFIE

31, DATE FILEO (Month, Day,

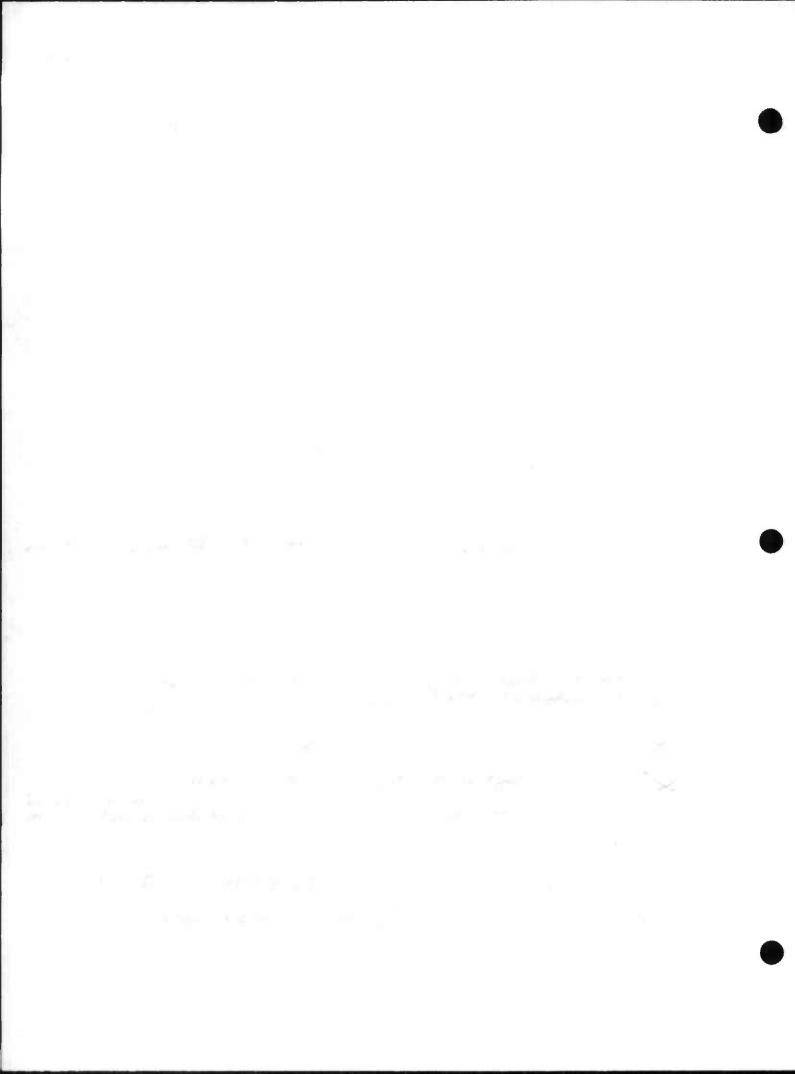
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE

1995

BE 2

CERTIFIC	ATE OF	DEATH	F	EG. NO.			
	elp.	5	2. DATE OF MONTH	DA		YEAR	3. TIME OF DEATH
	HTHE DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF E (Month, Da June	25,	1924	8. BIRTH	IPLACE (State or Foreign y) CL
9	Takoma	Park	EATH		Mont	gome	eath ery
1,742	own on loca						10d. INSIDE CITY LIMITS? XX YES 2 NO
	10	20912					WHAT COUNTRY? States
EVER IN U.S. ARMED YES ZYNO OR DATES	If yes, sp	ENDENT OF HISPAP ecify Cuban, Maxica 2 (NO Specify	in, Puarto Ricar	pecify Yes n, atc.)	or No-	14. RACE Black Speci	- American Indian, White, atc.
16a. DECEDENT'S US (Give kind of work life. Do NOT use n	done durina ma	ON sst of working	16b. KIN	D OF BUS	SINESS/IND	USTRY	
Office	•	r	Pr	ivat	е		
Lorenzen		18. MOTHER'S NA Myrtle			Sumama) Detle	ef	
		and Number or Rural I					- 3 20705
20b. PLACE AND DATE OF		s Drive	Beltsv		, Mar		
cemetery, crematory or other Parklawn Ce	metery	12/7/	1995	Roc	kvi11	e, N	Maryland
olt.	22. NAME A Dona1 4400	o Appress of FA d V. Bor Powder M	gwardt ill Rd	Fun Be	eral 1tsvi	Home	P.A., Md.20705
aused the death. Do not on each line. R AS A CONSEQUENCE OF:	<	tha			Soo		Approximate Interval Between Onset and Death
R AS A CONSEQUENCE OF):							
eth but not resulting in t	he underlying	g ceuse given in	4	PERFOR	MED?	24b.	WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
SE OF DEATH YES	NO Check only one)	UNCERTAIN	V 🗆				
0	THER:	Residence	8 Other (Sp	ecify)			
JURY Year) 28b. TIME O INJURY		RK?	28d. DESCRIE	BE HOW IN	JURY OCC	URED	
NJURY — At home, farm, stree . (Specify)	et, factory, offic		281. LOCATION City or To	N (Street a	nd Number	Rural R	Electronice. Le mal
r knowledge, death occurred a nination and/or investigation, i							and manner as stated.
_ wo		29c. LICENSE NUN	ABER 546		≥ DATE	SIONED	(Month, Day, Year) 4 95.
OF DEATH (ITEM 27) (Type, Pri		12186				73	mo :
SIGNATURE		0.36	Mism	-A	30		210000

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE



-TIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760 TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE HOSPITAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunal-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State begr. of Health and Mental Hyghere prior to bunal, cremation, or removal. IMPORTANT: If them 28 is marked, or them 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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										95	3	0410		
	1 - FOR STATE REGISTRAR	STATE OF MARY					EALTH AN	MENT	AL HYGIEN					
	1. DECEDENT'S NAME (First, Middle, Last)								E OF DEATH		T	3. TIME OF DEATH		
1	Geraldine B.	Price							November 29, 1995			W		
	4. SOCIAL SECURITY NUMBER		E (In yrs. les	t birthday)	JE UNDE	R 1 YEAR	IF UNDER 24 HR	NOVE		9. 19	95 I	BI ACE /State or Engine		
1	228-20-6905	1 □ M 2 🔀 F 7	3	YRS.	MONTHS	DAYS	HOURS MIN	Api	i129,	1922	Country Poin	Sparrows t, Maryland		
	9a. FACILITY NAME (If not inetitution, give at				9b. CIT	Y, TOWN O	R LOCATION OF	DEATH		9c. COUN	TY OF DE	ATH		
DIRECTOR	Fox Chase Nursin	ng Center			Si.	lver	Spring			Mont	gome	rv		
입	10a. STATE 10b. COUNTY	/		10c CITY	TOWN	OR LOCAT	ION		to a men			10d. INSIDE CITY		
H	i						n, D.C.			LIMIT				
	10e. STREET AND NUMBER			wa	SILLI		ZIP CODE		-	10- CIT/I		1 VES 2 NO		
FUNERAL	800 Infference Ct. N.E.													
Z	OUU JEIIERSON St., N.E. 20011 United St. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECEMBENT OF HISPANIC ORIGIN? (Specify Yea or No.— 14. RACI													
문	1 Never Married 2 Merried	FORCES? 1 TY	S 2 N	MED IO	13.	If yes, spe	ENDENT OF HIS solfy Cuban, Max	PANIC ORIG	IN? (Specify Yes o Rican, atc.)	or No-	14. RACE Black,	- American Indian, White, etc.		
B≼	3 🔀 Widowed 4 🗌 Divorced	IF YES, GIVE WAR OR	DATES	No		1 TYES	2 XNO Sp	eclly:			Specify	ack		
ED I	15. DECEDENT'S EDUC		T							1		ack		
12	(Specify only highest grade		(9)	Ve kind of w Do NOT use	ndr done	dudna mai	N st of working	10	Sb. KIND OF BUS	INESS/IND	JSTRY			
	Elementary/Secondary (0-12)	College (1-4 or 5+)							0 - 1 -					
COMPLET			16	ache	ľ				C Publi		nool	S		
8	17. FATHER'S NAME (First, Middle, Last) Walter B. BRoad						111.		, Middle, Maiden	Surname)				
H	waiter b. BRoad	nax					Alphi							
0	19a. INFORMANT'S NAME (Type/Print)	-							mber, City or Town					
🖹	Samuel O. Broadna	X	2	2108	Will	ow I	ree La	ne, T	emple H	lills	. Md	20748		
	20a. METHOD OF DISPOSITION	12	Ob. PLACE						TE 20c. LO					
	1 □ Burial 2 □ Cremation 3 □ Remo		emetery, cre	matory or oth	nar place)			12/5/	95 Brer		1 1/			
	21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEE	N h e l	шео	22.	NAME AN	D ADDRESS OF	FACILITY	MoCuine	LWOO	1. M	Service		
	Lynne I	1 m.a		60	74	.00 G	eorgia	Δπο	MCGUITE M U	rune	eral	Service		
Ш	offine o	· Mej	uce		Wa	shin	gton.	D.C.	20012					
	23. PART I. Enter the diseases, or c	omplications that caus	ed the de	ath. Do n	ot enter	the mod	de of dying, a	uch aa ca	rdiac or reapi	ratory arm	at,	Approximate Interval Between		
	IMMEDIATE CAUSE (Final													
	disease or condition	Pneumoni	2									Onset and Death		
1 1	resulting in death)		EOUENCE OF):								4 months			
-	Stroke													
0	Sequentially list conditions,	di .	E TO (OR AS A CONSEQUENCE OF):											
CERTIFICATION	if any, leading to immediate cause. Enter UNDERLYING				,							i l		
윤	CAUSE (Disease or Injury that Initiated events	DUE TO (OR AS	A CONSEC	UENCE OF										
ᄩ	resulting in death) LAST			12.12.5	,							i l		
圆		l												
. 1	PART II. Other algorificent conditions	a contributing to death	but not n	eaulting in	the ur	nderlying	cause given	In Part I.	24a. WAS AN	AUTOPSY	24b.	WERE AUTOPSY FINDINGS		
MEDICAL									PERFOR			AVAILABLE PRIOR TO COMPLETION OF CAUSE		
									1 TYES 2	Ø NO		OF DEATH?		
	DID TODA 600 1165 601 FF				_							1 TYES 2 NO		
Z	DID TOBACCO USE CONTR	RIBUTE TO CAUSE					UNCERTA	AIN KI						
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLAC	E OF DEATI										
S	1 TYES 2 X NO	1 Inpatient 2 ER/O	ulpatient 3	□ DOA	4 X Nur	H: sing Home	5 🗆 Residence	e 6 🗆 Ott	ner (Specify)					
포	27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year		28b. TIME	OF	28c. INJU		28d. DI	ESCRIBE HOW IP	JURY OCC	JRED			
ВУ	1 Netural 5 Pending 2 Accident Investigation	(Morall, Day, Year	<i>'</i>	INGC	M		ES 2 NO							
	3 Suicide 8 Could not be	28s. PLACE OF INJU	RY — At hor	na, farm, at	reet, fact	lory, office		28f. LO	CATION (Street a	nd Number o	r Rurai Ro	oute Number,		
臣	4 Homicide detarmined	building, etc. (Sp	оеспу)					Cit	y or Town, State)					
9	29a. CERTIFIER 1 CERTIFYING PHYSIC	MAN. To ab. 1				-								
29s. CERTIFFIER (Check only one) 1 CERTIFFING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and piece, and due to the cause(s) and one) 2 MEDICAL EXAMINER: On the best of examination and/or investigation, in my opinion, death occurred at the time, data and piece.									euse(a) and man	ner sa state	d,			
COMPLETED		t. On the besis of exeminat	non and/or li	rvestigation	, In my c	pinion, de	ath occured at 1	he Ilme, da	ta and place, and	dua to the	cause(a)	and manner as stated.		
ш	296. SIGNATURE AND PIECE OF MATERIAL	00	4	2.	10		29s. LICENSE N					Month, Day, Year)		
8	Matty	7/1	1	w	V		DO11	20		▶ De	cemb	er 4, 1995		
2	30 NAME AND ADDRESS OF REDSON WHO	COMMUNICATION CONTRACTOR	W. P. L.			_								

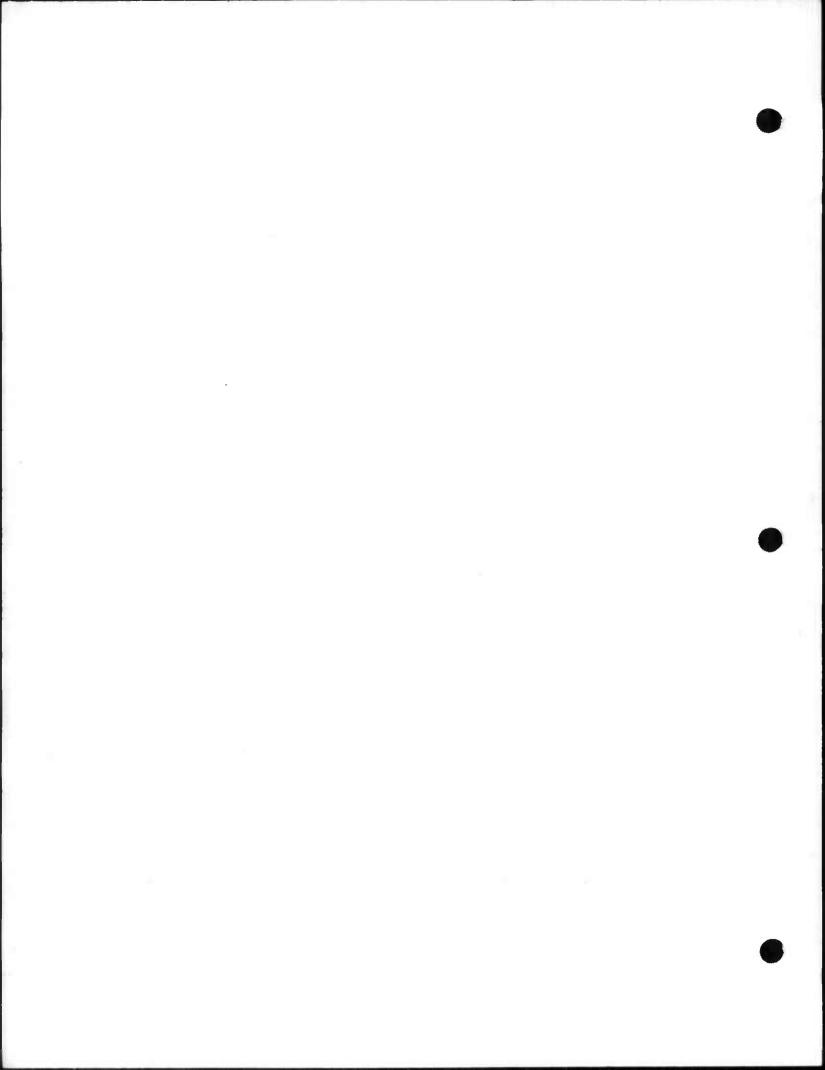
PLETED COUSE OF DEATH (ITEM 27) (Type, Print)

Walter Goozh, M 31. DATE FILED (Month, Dey, Year) DEC 05 1995

M.D.

2309 Shorefield Road, Wheaton, Maryland
32 REGISTRAR'S SIGNATURE
Julia dawsker Rosele





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 5 AM Certificate of Death 1. Decedant's Name (First, Middla, Last) 2. Date of Death 3. Time of Death Month Year **Physician** PATTERSON STEPHANIE VERNELL DEC. 06,1995 22:15 P /Medicai 4a. Facility Name (If not institution, giva street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner None 400 BLK.24th. ST. BALTIMORE If Undar 1 Yaar If Under 24 Hrs. 8. Date of Birth
(Month, Dey, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplaca (Stata or Foreign Country) Months Days 1□ M 25 F 047-64-9418 Yes. 30 Director April 19,1965 Connecticut Usual Rasidenca ot Decedent e filed within 72 hours after death with the Meryland al Hygiene.
other than "naturel", or items 23s or 28s-f show 10s State 10b. County 10c. City, Town or Location 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at Director 1 Yas 2 No Fairfield Danbury 10e. Street and Numbe 10f. Zip Coda 10g. Citizen of What Country? 06810 34 Patriot Drive, #A11 United States Funeral 12. Was Decedent Ever in U,S. Armed Forcas? 1 ☐ Yes 2 ② No If Yes, Giva Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuben, Maxican, Puerto Rican, etc.) 14. Race - Amarican Indian, Black, White, etc. XX Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 🖾 No Specify: þ Specify: 3 ☐ Widowed 4 ☐ Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grade completed) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) Coilega (1-4or 5+) Certified Nurses Assistant Hospital 12 permit. Peges 1 and 2 should be file Department of Health and Mental Hy Important: If flem 27 is marked othe any Injury or other traumatic event, 9068. 17. Fathar's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Surnama) Be Cordell Patterson Dorothea R. Wilson 2 19a. Intormant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Dorothea R. Patterson 34 Patriot Drive, #A11, Danbury, Connecticut 06810 20b. Place of Disposition (Name of cemetery, crametory or other plece) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Wooster Cemetery Dec.11,1995 Danbury, Connecticut 22. Name and Addrass of Facility Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc., 7557 Wisconsin Ave. 21. Şign dure ot Funerai Service Licensee Bethesda-Chevy Chase, Inc., 75 Bethesda, Maryland 20814-3501 nulla M00348 23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart tailure. List only one ceuse on each line. Approximate interval Between Onset and Death **Physician** /Medical immediate Cause (Final diseasa or condition resulting in death) Examiner Due to (or as a consequence of) Examiner The law requires that the death certificete be executed buriai-transit Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. physician Physician/Medical the Due to (or as a consequence of): ed by the a P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 2 No signed by i 3 Probably 4 Unknown 1 Yes by 24a. Was an autopsy performed? 24b. Were autopsy tindings available prior to completion of cause ot death? peed hes 2 No

Division of Vital Records, certificate I or Attending Physician: after death.
Director: After this certifica

Completed Be

Certification: To 2

25. Was cese reterred to medical 1X Yes 2 No

27. Manner of Death 1 Netural 5 Pending

2 Accident 3 Suicide 4 Homicide

29s. Certifier

Investigation 8 Could not be determined

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Data of Injury (Month, Dey Year) 2-6-95

28b. Tima of 2210

AUD

28c. Injury at Work? 28e. Place of Injury - At home, farm, straet, tactory, office building, etc. (Specify)

1 Yes 2 No

Sheet 8 451 281. Location (Street end Number or Rural Route Number, City or Town, Stete) 100 asi

Other: 4 \square Nursing Home 5 \square Rasidance 8 \square Other (Specify) STREET

28d. Describe how injury occurred

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end piece, and due to the cause(s) and manner as stated. Medical Examiner: On the besis of examination and/or investigation, in my opinion, death occurred et the time, date end piece, and due to the cause(s) and manner stated. 29b. Signatufreland title of certifier

29c. Licensa number OCME

29d. Data signed (Month, Dey, Year)

DEC.07,1995

ceuse of death (Item 23a) (Type, Print) de

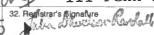
111 Penn Street, Baltimore, Maryland 21201

28. Piece of Deeth (Check only one)

State Registrar

Medical

31. Date tiled (Month, Dey, Yeer) 08 1995

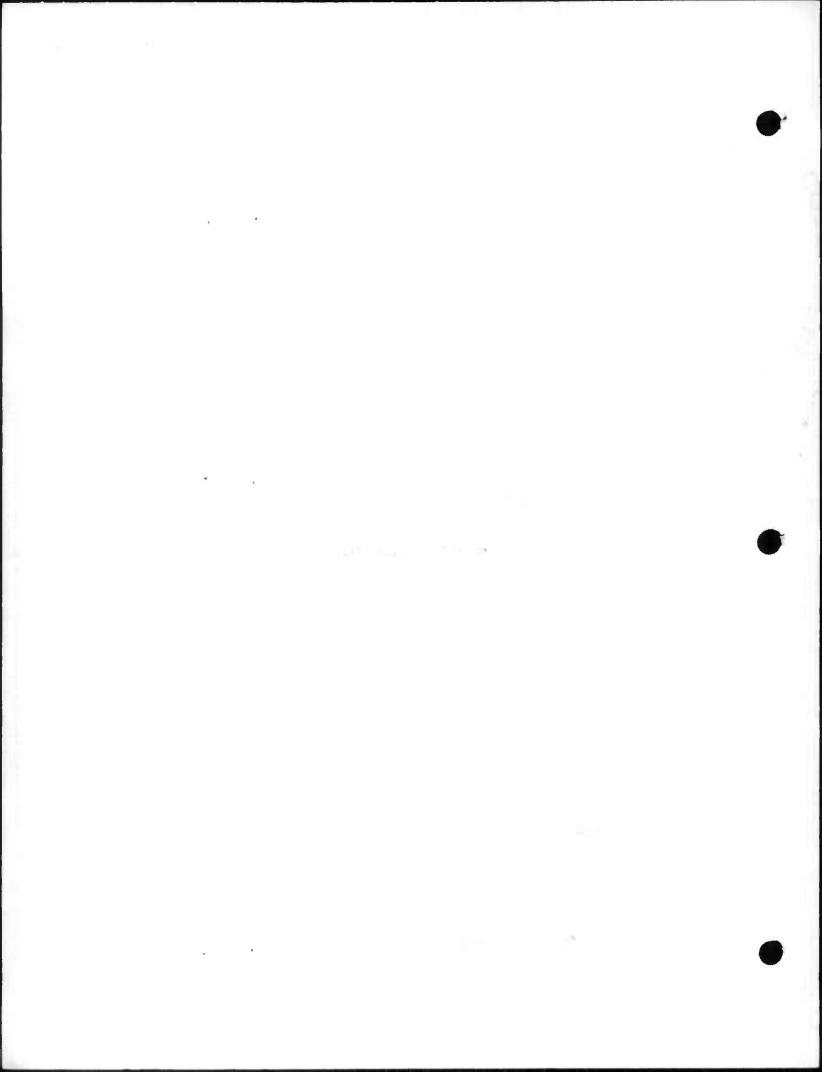


To the Hospital of within 24 hours a To the Funeral D completely filled

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director page 5 should be detached for use as the buriat-transit narmit pages 1.9.3 executed
be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND	MENTAL HYGIENE
CERTIFICATE OF DEATH	REG. NO.
	The second second second

	1 - FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPAR CERTIF	TMENT OF I	HEALTH AND	MENTAL HYGIE		,				
	1. DECEDENT'S NAME (First, Middle, Last)			1		2. DATE OF DEATH		3. TIME OF DEATN				
	JAMES 1	nontgomer	4 tuk	5/011		TOCCEMBLE P	DAY 13	795 6:15 Am				
	4. SOCIAL SECURITY NUMBER		yrs. last birthday)	IF UNDER WEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH		. BIRTNPLACE (State or Foreign				
	139-30-4365	1 1 1 2 F	SCO YRS.	MONTHS DAYS	HOURS MIN.							
	9a. FACILITY NAME (If not institution, give si	treet and number)	4	9b. CITY TOWN	OR LOCATION OF D		4	Y OF DEATH				
Œ	21425 York Rd.	•			land Li			LTO				
K I	RESIDENCE OF DECEDENT						0"	210				
DIRECTOR	10a. STATE 10b. COUNTY		TION		,	10d. INSIDE CITY						
	MUBA	LTIMORE	2142	5 WORK	Rd M	ARYLAND	Line	LIMITS?				
A	10. STREET AND NUMBER	,		N OF WHAT COUNTRY?								
FUNERAL	21425 york	- Rd			21105 US							
5	11. MARITAL STATUS	12. WAS DECEDENT EVER IN	U.S. ARMED		MS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No - 14. RACE - Amer							
ВУ	1 Never Married 2 Married 3 Wildowed 4 Divorced	FORCES? 1 YES			ecity Cuban, Mexico 2 NO Speci	en, Puerto Rican, etc.)		Black, White, etc.				
	3 Widowed 4 Divorced							speciny: white				
COMPLETED	15. DECEDENT'S EDUC (Specify only highest grade		16a. DECEDENT'S	USUAL OCCUPATION done during me	ON est of working	16b. KIND OF B	USINESS/INDUS	STRY				
"	Elementary/Secondary (0-12)	College (1-4 or 5+)	Ille. Do NOT use	retired.) urante:		foo	ج					
M		2	Resta	ii aii te t								
8	17. FATHER'S NAME (First, Middle, Last) Robert Montgor	mory Durele	37		16. MOTNER'S NA	ME (First, Middle, Maide	n Sumame)					
BE		acry rursic	-		Mary							
٩	19a. INFORMANT'S NAME (Type/Print)	1	19b. MAILING	AODRESS (Street of	and Number or Rural	Route Number, City or To	own, State, Zip Co	ode)				
	Victoria Purs					aryland L						
	29a METHOD OF DISPOSITION 1 A Buriel 2 Cremetion 3 Remo	oval from State 20b.	PLACE AND DATE O	F DISPOSITION (No	aney I			y or Town, State				
	4 Donation 6 Other (Specify)	Va	atary, cramatory or off 11ev Mem			2200	monium	, MD				
	1	Note 1			Uarton			. Two				
	Saran Del	Hale Sul		24	Second	stein Mo	r tuary	om, PA 17349				
	23. PART I. Enter the diseases, or c ahock, or heart failure. I	ome cations that caused	the death. Do n	ot anter the mo	de of dying, auc	h as cardiac or rea	piratory arrea	it, Approximata				
	IMMEDIATE CAUSE (Final	Ties only also carres on ea	ich line.					Interval Batween Onset and Death				
	disease or condition reaulting in death)	Lune	1/2	noa.				2005				
	DUE TO (OR AP 1/CONSEQUENCE OF):											
Z	Sequentially list conditions, b.											
티	If any, leading to immediate											
2	CAUSE (Disease or injury	h.										
# 1	that initiated events resulting in death) LAST	OUE TO (OR AS A	CONSEQUENCE OF):								
CERTIFICATION	de de la contra del contra de la contra de la contra del la contra de la contra de	i										
AL C	PART II. Other algnificant conditions	s contributing to death by	it not resulting in	the underlying	cause given in	Part I. 24s WAS A	N AUTOPSY	24b. WERE AUTOPSY FINDINGS				
<u>র</u>		-			,	DEDE	RMED?	AVAILABLE PRIOR TO COMPLETION DF CAUSE				
8						1 _ YES	2 NO	OF DEATH?				
2	DID TOBACCO USE CONTR	DIRLITE TO CALISE OF	DEATH YES	E PL NO E	LINICEDTAL			1 TYES 2 NO				
₹	25. WAS CASE REFERRED TO MEDICAL		6. PLACE OF DEAT	100	UNCERTAI	4 L		4				
PHYSICIAN: MEDIC	EXAMINER?	HOSPITAL: 1 Inpatient 2 ER/Outpa		OTHER:	. d	X						
Ξ	27. MANNER OF GEATH	28a. DATE OF INJURY	28b, TIME			6 ☐ Other (Specify) 28d. DESCRIBE HOW	IN HIEV OCCUS	DED.				
	Metural 5 Pending	(Month, Day, Year)	INJU	IRY WO	RK?	200. DESCRIBE HOW	INJURY OCCUP	NED				
è l	2 Accident Investigation 3 Suicide & Could set be	28a. PLACE OF INJURY	At home, term, at			281. LOCATION (Stree	t and Alumber or	Dural Bauta Murahas				
	4 Homicide 8 Could not be determined	building, atc. (Specia	(y)	, , , , , , , , , , , , , , , , , , , ,		City or Town, Stat	e)	nurar noute number,				
"	29a. CERTIFIER											
물	(Check only one)	CIAN: To the best of my knowle	edge, death occurred	f at the time, date	and place, and due	to the cause(a) and m	anner sa stated.					
COMPLETED			end/or investigation	, in my opinion, d	earn occured et the	time, date and place, a	and due to the c	cause(a) and manner as stated.				
띪	206. SIGNATUSE AND TITLE OF GENTIFIER	110			29c. LICENSE NUI	ABER	29d. DATE S	IGNED (Month, Day, Year)				
ှု မြ	July July	100]			2309	19	13	2/14/95				
	SO NAME AND ADDRESS OF PERSON WHO		010		00 0000	1 40:	0 1	/				
	Toul Celano NO	6569 N	Charle,	ST	HUMUL	m 2	1209					
	DEC 2 0 1005	32 REGISTRAR'S SIGNA	P									
	7=- % ~ [333	June marter	randall.			•						
	A							OHMH-16 Rev 1/89				



asp ITEMS: 23 PART I, 27, PER MEO

ment of Health and Mental	Hygiene	95	3841
icate of Death			

	FIL	.M G	-731 1/3/96 t.t		0. 1110	-		tificate			i Mentai F	Reg.		, ,	304	1 3
	Ohusia		1. Decedent's Neme (First, Midd								2. Dete of		Day	Voor	3. Time	of Death
	Physic /Med		DANIEL		CALH	OUN		R	OPE	R, IV	DEC	DEC 04 Day 1			2:1	.8 P
)	Exami		4a. Fecility Nema (If not Institution DOCTORS COM	n, <i>giv</i> a s <i>treet</i> end t		SPITAL				City, Town, CLANHA	or Location of De		4c. County PRIN	of Death CE GEORGES		
	Funeral Director		5. Social Security Number 216-45-0974	6. Sex 1 X M 2 ☐ F		(In yrs. lest birth	hday) (rs.	Months E	eys	If Undar 24 H Hours M	in. 8. Deta of (Month, Sept.	Birth Dey, Ye	ar) 1995		plece (Stets ntry) vland	or Foreign
5-0020 72 hours after death with the Maryland	with the Maryland a or 28a-f show be notified	Director	10e. Street and Number	Arundel		10c. City, Town		10f. Zip Co					Citizan of V	What Cou	nlry?	s 2 No
	n 72 hours after deeth with the Marylar *netural", or items 23a or 28a-f show spical Expansion must be notified at	by Funeral	1604 Ridout Roa 11. Marital Status 1 Never Married 2 Mar 3 Widowed 4 Divorced	12. Wes Do Armed 1 2 Ye	I Ves 2 No If Yes, Give 1 Yaer or Dates:			21401 Was Decedent of Hispanic Origin? (Specify Yas or Notif Yas, specify Cuban, Mexicen, Puarto Rican, atc.) □ Yes 2♥ No Specify:					United States of Am 14. Race - American Indian, Black, White, etc. Specify: White			Ameri
Maryland 21215-0020	within 72 ho lene. than *natur	Completed	15. Deceder (Specify only highs Elementery/Secondery (0-12)					16e. Decedent's Usuel Occupet (Give kind of work dona du life. DO NOT use retired)			petion during most of working d)			16b. Kind of Business/Industry		
2	D 00 5	S	0			In	fant	t - N/					/A			
/land	8 <u>a</u> a 8	To Be	17. Father's Neme (First, Middle, R. Bruce Roper						Marie (len Sumam	ia)				
au	E E E		19a. fnformant's Neme/Reletions	ship (Type, Print)		19b.	Meiling	Address (S	treet an	nd Number or	Rural Route Nu	nber, Cit	y or Town,	State, Zip	Code)	
			Bruce & Janice	Roper -	Pare	nts 16	04 I	Ridout	Ro	ad, An	napolis	Man	rylan	d 214	401	
	y or T		20e. Method of Disposition 1 \text{\text{M}} \text{Burial} 2 \text{\text{Cremetry}} \text{Creek Cemetery} \text{ 20c. Location - City or Town, State} \\ 4 \text{\text{Donellon}} 5 \text{\text{Other (Specify)}} \\ 21. Signeture of Funeral Service Licensaci													
Bal	Departme Departme Importan any Injur once		21. Signeture of Funeral Service 23a. Pert 1. Enter the disease, or shock, or haert failure. List	F, BC	200 et ceused I	he death. Do n	Fra 473	ancis 39 Bal	Gas	ch's Sore Av	ons Funde., Hyat	tsv			yland Approximation	ala etween
1	hysician /Medical Examiner		Immediate Cause (Final disease or condition resulting in daath)	a	SUDDEN	INFANT D	EATH	SYNDRO	ME						Onsal and	d Death
		-i-			C	oua to (or as a c	onsequ	ance of):								
, O	physician and the burial-transit	Examiner	Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury	Б	D	ue to (or es e c	onsequ	ance of):								
×	oding sa as	in/Medical	the initiated events resulting in death) Lest Due to (or es a consequence of):													
5	by the	Physician/M	Part II. Other significant condition	one contributing to	death but	not resulting in	the und	darlying caus	se given	In Pert I.			co uae cor		o the cause bably 4[
	been signed	Completed by									24a. W	as an au erformed	itopsy	av	ere autopsy allable prior emplation of death?	rto
a L	ata he page										1	Yes	2 🗆 No	11	Yes 2	□No
\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	s cartificata director, pag	Be	25. Was case raferred to medice examiner?								eeth (Check on	y ona)				
OI VILO	this ald	2	1 X Yes 2 No			2 ER/Out		XXDOA	Other	4 LI IAMISHIN	Home 5 R				(y)	
VISION		tification:	27. Mennar of Death 1 Naturel 5 Pendir 2 Accident investi	getion	te of Injury onth, Day	Year) 28b. Ti	me of jury	M 28c.	Injury a Work?	es 2 No	28d. Descrit	e how in	njury occurr	red		
5	45	‡	3 ☐ Sulcida 6 ☐ Could 4 ☐ Homicida determ	ined 288. Pie	ce of Injur	y - At home, fen	m, sirae	et, fectory, of	ffice		28f. Locatio	(Street Town, St	end Numb	er or Run	al Route Nu	mber,

To the Hospital or Atland within 24 hours after death within 24 hours after death To the Funeral Director: / completely filled in by the 1

1 Certifying Phyeician: To the best of my knowledge, death occurred et the Ilma, dete and place, end due to the ceuse(s) end menner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, dete end place, and due to the cause(s) end menner steted. 29b. Signature end titla of certi

29c. License number O.C.M.E

29d. Data signed (Month, Day, Year) DEC 05, 1995

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

who completed course of death (Item 23e) Type Print Penn Street, Baltimore, Maryland 21201 MARYA CUR

State Registrar

Medical Certifica

29a. Certifier (Check only one)

31. Data filed (Month, Day, Year)

DEC 8



nange et Manda et name til de skriver et name til de skriver et name til de skriver et name til de skriver et n Light of the skriver et name til de skriver et name til de skriver et name til de skriver et name til de skriver

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retained by the hospital or attending physician.

BALTIMORE, MARYLAND 21215-0020

BOX 6876 0 DIVISION OF VITAL RECORDS,

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DEC 04 1995

Pages 1, 2, 3 should permit. the bunal-transit 38 use Jou detached once. 2 76 page 5 should notified 24 hours after death. Page 6 may be pe must director, examiner funeral the medical filled in by the completely traumatic event, bunal. and 9 physician 2 prior other t ental Hygiene p 0 requires that the death the atten Injury. been signed by the any Shows Dept. O OR ATTENDING PHYSICIAN: The law Hem certificate to the State the this co marked, After death .00 DIRECTOR: A 28 Hem FUNERAL D within 72 h HOSPITAL TO THE HOSPITA
TO THE FUNERAL
BE filed within 72
IMPORTANT: II

95 38480 STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR CERTIFICATE OF DEATH REG NO 1. DECEDENT'S HAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH DECEMBER 1, 1995 3:10 WILLIAM BRIAN RICHARDSON PM 4. SOCIAL SECURITY HUMBER 5 SEY 7. DATE OF BIRTH (Month, Day, Year) 8. BIRTHPLACE (State or Foreign Country) IF UNDER 1 YEAR IF UNDER 24 HRS. 1 🕅 M 2 🗆 F May 23. 216-74-0253 Washington, 9a. FACILITY HAME (If not institution, give street 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR RT.24 & SINGER ROAD HARFORD COUNTY 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY 1 TYES 2 THO Maryland Anne Arundel Severn 10e. STREET AND NUMBER 101. ZIP CODE FUNERAL 10g. CITIZEN OF WHAT COUNTRY? 8019 Ponderosa Drive 21144 USA 12. WAS DECEDENT EVER IN U.S. ASMED FORCES? 1 YES 2 NO 13. WAS DECENDENT OF HISPAHIC ORIGIN? (Specify Yea or No-If yea, specify Cuban, Mexican, Puerto Rican, atc.)

1 YES 2 NO Specify: 14. RACE — American Indian, Black, White, atc. FORCES? 1 YES 2 1 N Hever Married 2 Married Specify BY 3 Widowed 4 Divorced White ED 15. DECEDENT'S EDUCATION 16e. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only high (Give kind of work done life. Do NOT use retired.) est of working Е College (1-4 or 5+) Elementary/Secondary (0-12) COMPL College Student 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Ronald Lee Richardson Joanne (nmn) Phipps BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5 Ronald Lee Richardson 8019 Ponderosa Dr., Severn, Maryland 21144 20a, METHOD OF DISPOSITION
1 M Surial 2 Cremation 3 4 Donation 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State Bel Air Memorial Gardens 12-5-95 Bel Air, Maryland 22. NAME AND ADDRESS OF FACILITY 23. PART I. Enler the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory streat, shock, or overt fellure. List only one cause on each line. Howard K. McComas III Funeral Home 21009 1317 Cokesbury Rd., Abingdon, Md. Approximate interval Batween **Onsat and Death** resulting in death) DUE TO (OR All CERTIFICATION Sequentially liet conditions, DUE TO (OR AS A CONSEQUENCE OF) If sny, leeding to immediate cause. Enter UNDERLYING CAUSE (Disesse or Injury DUE TO (OR AS A CONSEQUENCE OF) that initieted evente resulting in deeth) LAST 24a. WAS AN AUTOPSY PERFORMED? PART II. Other significent conditions contributing to deeth but not resulting in the underlying cause given in Part i. 24b. WERE AUTOPSY FINDINGS MEDICAL AVAILABLE PRIOR TO COMPLETION OF CAUSE YES 2 NO DEATH? YES 2 | HO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one HOSPITAL: OTHER 1 X YES 2 NO 1 | Inpatient 2 | ER/Outpatient 3 | DOA AT 26d. DESCRIBE HOW INJURY OCCURED for Che 6 27. MAHNER OF DEATH 26a. DATE OF INJURY 28b. TIME OF 26c. INJURY AT WORK? 1 Natural
2 Aculdent 1430HR 1 YES 2 BY wehick Investigation 28a. PLACE OF IHJURY - At home, farm, Suicide street, lectory, office 281. LGCATIOH (Street and Nu 6 Could not be determined COMPLETED ity or to road War 29a. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and make the time. Sold bross. 4 on and/or investigation, in my opinion, death occured at the time, data and place, and due to the cadeo(a) and menner on stated. 2 XMEDICAL EXAMINER: On the basis of examin 29c. LICENSE NUMBER 29d, DATE SIGNED (Month, Day, Ybar) BE Ken O.C.M.E. DECEMBER 2,1995 re D

OF DEATH (ITEM 27) (Type, Print)

62, REGISTRAR'S SIGNATORE

111 Penn Street, Baltimore, Maryland 21201

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 6876

		FOR 1 - STATE REGISTRAR	STATE OF MARYLA		TMENT OF H		ENTAL HYGIEN	E				
		1. DECEDINT'S NAME (First, Middle, Last)	Proberts				2. DATE OF DEATH	5 9	3. TIME OF DEATH 5 //00 M			
2		4. SOCIAL SECURITY NUMBER 135-03-9139	1 M 2 D F 85	n yrs. last birthday) YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) Feb 21, 1		BIRTHPLACE (State or Foreign Country)			
2, 3 should	стов	90. FACILITY NAME (If not inetitution, give s St. Agnes Hospita				R LOCATION OF DEA	тн	Baltimore				
Pages 1.2	DIRECT	10a. STATE 10b. COUNT	Y		Y, TOWN OR LOCAT				10d. INSIDE CITY LIMITS?			
permit.	ERAL D	Maryland Balt 100. STREET AND NUMBER	inore	B	altimore 101	. ZIP CODE		10g. CITIZEN	1 YES 2 NO			
an. ransit	Ä	711 Academy Road				21228			ed States			
be retained by the hospital or attending physician. ge 5 should be detached for use as the bunial-transit ne notified at once.	BY FUN	11. MARITAL STATUS 1 Never Merried 2 Merried 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR DA	2 NO								
al or attend for use as	ETED	15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12)	JCATION o completed) College (1-4 or 5 +)	(Give kind of life. Do NOT u		ON st of working		b. KIND OF BUSINESS/INDUSTRY				
he hospit detached once.	COMPL	unknown		unknow	n		unkno					
by the hose detach	_	17. FATHER'S NAME (First, Middle, Last)	houte				E (First, Middle, Maiden		:: -1.4			
should by	BE	Wyatt Marshall Ro	Derts	401- 144-11 1917	ADDRESS (Summar		ine Bell C					
5 should	2	Patricia Mulvenna	9			oute Number, City or Tow CVille, Ma						
ector, page must be		20g. METHOD OF DISPOSITION 1	20b.	PLACEANDDATE	of disposition (Na other plece) herd Cem	ame of		CATION City	or Town, State			
tuneral director, xaminer must	-1	21. SIGNATURE OF FUNERAL SERVICE LI		ou silep	22. NAME AN	ND ADDRESS OF FAC	LITY					
rs after death. Pag n by the funeral di removal.		> Sham q.	Collins		4112	Old Colum		Ellico	ott City 21043			
within 24 hour operally filled in cremation, or nent, the me		HIMPERIATE CALLOE (Final	List only one ceuse on es	sch line.		•			Interval Between			
ficate be execu physician and ne prior to bur	RTIFICATION	disease or condition resulting in death) Ce regrovas cultar accelerat DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated eventa resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):										
attending mtal Hygie	CER	resolding in death) EAST	d									
The the	MEDICAL C	PART II. Other algnificent condition	ns contributing to deeth be	ut not resulting	in the underlying	g cause given in f	Pert i. 24a. WAS AN PERFOI	RMED?	24b. WERE AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO			
has been Dept. of the		DID TOBACCO USE CONT				UNCERTAIN						
SICIAN: The las certificate has the State Dep 1, or item 23	SICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO	HOSPITAL:		OTHER:	ne 5 🗆 Raeldence 8	Other (Specify)					
NG PHYSICIA feer this certification with the marked, or	РНҮ	27. MANNER OF DEATH	28s. DATE OF INJURY (Month, Day, Year)	26b, TII	ME OF 28c. INJ		28d. DESCRIBE HOW	INJURY OCCUP	RED			
TTENDI TOR: A after de	ETED BY	Accident Investigation 3 Suicide 6 Could not be determined	26e. PLACE OF INJURY building, etc. (Spec	— At home, farm,			281. LOCATION (Street end Number or Rural Route Number, City or Town, State)					
西京	COMPLE	one)	SICIAN: To the best of my knowl						euse(s) end menner as stated.			
TO THE HOSPI TO THE FUNER DE filed within	ш	29b. SIGNATURE AND TITLE OF CERTIFIE	ER		`	29c. LICENSE NUM	BER	29d. DATE S	IGNED (Month, Day, Yeer)			
TO THE DE filed IMPOR	TO B	30. NAME AND ADDRESS OF PERSON W	22 CLU GOS	M	(Print)	D184	84	> 1(/	25795			
1	į	H. TAVASSO	LIEMO 34	55 W,	LKENS	AVE #3	06 BAL	TMD	21229			
J		31. DATE FILED (Month, Day, Year) NOV 2, 8, 1991		ATURE								

BALTIMORE, MARYLAND 21215-0020

1 - FOR STATE REGISTRAR

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within. A hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If them 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

	1. DECEDENT'S NAME (First, Middle, Lest) 2. DATE OF DEATH MONTH DAY YEAR 3. TIME OF DEATH													
	ETHEL		L.		ROLLI	NS			Dec.	6	1995	8:20 P. M		
	4. SOCIAL SECURITY NUME		5. SEX	8. AGE (In yra	. last birthday)	IF UNDER	1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRT	TH had	0. BIRTH	BIRTHPLACE (State or Foreign Country)		
	231 01 88		1 M 2 X F		79 YRS.	MONTHS	DAYS	HOURS MIN.	Aug. 2			ewville,VA.		
~	9e. FACILITY NAME (If not in		,			9b. CITY	r, TOWN	OR LOCATION OF D	EATH	9c. C	OUNTY OF D			
Ö	Carriage	Hill N	ursing C	enter		S	ilve	r Spring	Montgomery			omery		
DIRECTOR	10e. STATE	10b. COUNTY			10c. CI	10c. CITY, TOWN OR LOCATION					10d. INSIDE CITY			
	Maryland	Mon	ntgomery		S	ilve	r Sn	ring				LIMITS?		
AL	10e. STREET AND NUMBER							I. ZIP CODE		10g. (CITIZEN OF	WHAT COUNTRY?		
E	9101 Seco	nd Str	eet					20910			Unite	d States		
FUNERAL	11. MARITAL STATUS 1 Never Merried 2	Married	12. WAS DECEDEN	T EVER IN U.S.	ARMED NO	13.	WAS DEC	CENDENT OF HISPA	NIC ORIGIN? (Spec	E — American Indian, ix, White, etc.				
BY	3 💢 Widowed 4 🗌 Divo		IF YES, GIVE Y	WAR OR DATES				2 X NO Specif		" Black				
	15. DEC	EDENT'S EDUC	ATION	16a	DECEDENT'S	USUAL O	CCUPATIO	ON	16b. KIND (F BUSINESS/	INDUSTRY			
COMPLETED	Elementary/Secondary (0	y highest grade 1-12)	College (1-4 or 5	+)	life. Do NOT u	se retired.)		est of working						
MP	12				Corre	ctio	n Oi	ficer	D.	C. Gov	ernme	nt		
	17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Melden Surname)													
BE	Robert Chinn Rebecca Cole 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street end Number or Rural Route Number, City or Town, State, Zip Code)													
2	Myrna Gra			- 1								06		
1	20s, METHOD OF DISPOSIT 1 🖾 Burlel 2 □ Crematio	ION	-	20b. PLA	CEANDDATE	OF DISPOS	SITION (Na			nham, Maryland 20706				
į	4 Donation 5 Other		val from State	cemetery.	ingto:	n Nat	ion	al Cem.	12/14/95	Arli	rlington, VA.			
'	4 Donation 5 Other (Specify) Arlington National Cem. 12/14/95 Arlington, V. 21. SIGNATURE OF EINERAL SERVICE CLEMBER 22. NAME AND ADDRESS OF FACILITY McGuire Funeral Service Inc.													
	1 Xu	run	v 2.	Ha	eth			Georgia				20012		
7	23. PART I. Enter the di	seases, or c	omplications the	t caused tha	death. Do	not enter	the mo	de of dying, auc	h aa cardiac or	reaplratory	arreat,	Approximata		
V	IMMEDIATE CAUSE (FIG		.io: Only Olia Cat	or on each								Interval Between Onset and Death		
	disease of condition resulting in death) a. OUE TO (OR AS A CONSEQUENCE OF):											72 dg		
	Lina Cancer													
MEDICAL CERTIFICATION	oue to (or as a consequence of):													
S	CAUSE (Disease or Injury													
	that initiated events resulting in death) LAS	·	DUE TO	(OR AS A CON	SEOUENCE O	F):								
CER														
A	PART II. Other algnifica	nt conditions	contributing to	deeth but no	ot resulting	In the ur	ndarlying	g cause given in		AS AN AUTOPS	SY 24b	WERE AUTOPSY FINDINGS		
8										ES 2 KNO		AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?		
ME									_		1	1 YES 2 NO		
N.	DID TOBACCO U		IBUTE TO CA					UNCERTAIL	N 🗆					
PHYSICIAN:	25. WAS CASE REFERRED TO EXAMINER? 1 YES 2 X NO	MEDICAL	HOSPITAL:		LACE OF DEA	OTHE	R:							
H	27. MANNER OF OEATH		1 Inpatient 2 28e. DATE OF		28b. TIN		sing Hom 28c. tNJ	e 5 Residence	8 Other (Specification 28d, DESCRIBE)		OCCUBEO			
ВУР		Pending Investigation	(Month, D	ey, Year)	IN.	JURY M	WO	PRK?			00001120			
	3 Suicide 8	Could not be	28e. PLACE O	F INJURY At	t home, ferm,	atreet, fect	lory, office	•	281. LOCATION (S City or Town,	Street end Num	ber or Rural F	Route Number,		
COMPLETED	4 Homicide	determined							Only or rown,	Siele/				
4PL		(Check only 1 A CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) and manner as stated.												
Į	2 MEDI	one) 2 MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(e) end menner ee stated.												
BE	296. SIGNATURE AND TITLE	OF CERTIFIER	11.)					29c. LICENSE NUI		29d. D	ATE SIGNED	(Month, Day, Year)		
2	30. NAME AND ADDRESS OF	wheny	WV					W434	16	•	Dec.	6 1995		
	M 5HAMM AT	1	HALID	SE OF DEATH (11EM 27) (Type	Print)	77	D434 9	Si Lon Ci	2 rm	mp	20902		
H	31. DATE FILEO (Month, Day.	Year)	411	R'S SIGNATUR	- Win	wyc	n d	1000	01 77 4 3					
	DEC 08 19	95 4	lin d'aude	A'S SIGNATUR	4									
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HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be exe	TOR.	within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
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FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 -CERTIFICATE OF DEATH REG NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH 1995 DEC. **ROBERTSON** O'BRIEN FELIDE 9:13 A 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. lest birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH
(Month, Day, Year)
July 9, 1909 8. BIRTHPLACE (State or Foreign 465-72-3092 1 M 2 X **Texas** 9a. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Friends Nursing Home Sandy Spring Montgomery RESIDENCE OF DECEDENT 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? Maryland Montgomery Sandy Spring 1 TYES 2 K NO FUNERAL 10a. STREET AND NUMBER 101. ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? 20860 17342 Quaker Lane United States 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No—If yea, specify Cuben, Mexican, Puerto Rican, etc.)
1 YES 2 X NO Specify: 12. WAS DECEDENT EVER IN U.S. ARMED 14. RACE — American Indian, Black, White, etc. FORCES? 1 YES 2 1 Never Married 2 Married BY Specify: 3 (Widowed 4 Divorced White 8 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only high (Give kind of work done life. Do NOT use retired.) ET Elementery/Secondery (0-12) College (1-4 or 5+) COMPL 4 Housewife Own Home 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Surname) Stephen O'Brien Decatur Nonie Crain BE 190. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street end Number or Rural Route Number, City or Town, State, Zip Code) 2 Charles James Robertson III 1516 - "T" St, NW Washington, DC 20009 200. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State 206. METHOD OF DISPOSITION

1 | Burlel 2 | XCremation 3 | Ramoval from State

4 | Donation 5 | Other (Specify) | Chesapeake Crematory Beltsville, MD 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Rapp Funeral Services, P.A. M00827 933 Gist Ave, Silver Spring, MD 20910 11 23. FART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one cause on each line. shock, or heart fallure. List only one cause on each line. interval Between Onset and Death IMMEDIATE CAUSE (Final disease or condition who resulting in death) CERTIFICATION Sequentially list conditions, If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART ii. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part i. 24s. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS MEDICAL AVAILABLE PRIOR TO COMPLETION OF CAUSE 1 TES 2 X NO OF DEATH? 1 YES 2 X NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐ UNCERTAIN ☐ PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one EXAMINER? HOSPITAL: OTHER:
4 X Nursing Home 5 Residence 6 Other (Specify) 1 | Inpetient 2 | ER/Outpetient 3 | DOA 27, MANNER OF DEATH 26e. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT WORK? 26d, DESCRIBE HOW INJURY OCCURED 1X Natural 5 Pending 1 YES 2 NO BY Investigation 2 Accident 3 Sulcide 28e. PLACE OF INJURY — At home, farm, streel, fectory, office building, etc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined COMPLETED 4 Homicide 29e. CERTIFIER
(Chack only 1 X) CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data end place, and due to the cause(s) and manner as attend. 2 MEDICAL EXAMINER: On the beele of examination end/or investigation, in my opinion, death occurred at the lime, date end place, and due to the cause(e) and manner se stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d, DATE SIGNED /Moreth, Day, World BE

lo le 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DILATH (ITEM 27) (Type, Print)

17904 Georgia Ave #304, Olney, MD 20832-2239

Thomas E. Dooley, M.D. 32. REGISTRAR'S SIGNATURE Tali Davelson Reveal

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Dec. 6, 1995

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THE HOSPITAL OR ATTENDED PROJECTION OF THE HOSPITAL THE COLOR 50 FOO. THE HOSPITAL DISCORDAN FOR A MARKET HIS CARRIED PROJECTION. The law requires that the death certificate be executed within 72 hours after death or for the hospital or attending physician. The FUNERAL DISCORDAN After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should have 28 is marked, or letten 28 is marked, or letten 23 shows any injury, or other traumatic event, the medical examiner must be neutified at once.	BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION	23. PA IMME disea: result Seque if any cause CAUS that is result PART 25. WAS EX. 1 C 27. MAN 1 X 2 C 3 C CC One

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	FOR STATE REGISTRAR		STATE OF I	MARYLAI	ND / DEPAR					MENTA	L HYGIEN					
	1. DECEDENT'S NAME (First, A	Middle, Last)									OF DEATH			3. TIME OF DE	EATH	
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1	4. SOCIAL SECURITY NUMBER	R	5. SEX	6. AGE (In	yrs. lest birthday)	IF UNDER 1	YEAR DAYS	IF UNDER			OF BIRTH h, Day, Year)		8. BIRTI	IPLACE (State or	Foreign	
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1	9e. FACILITY NAME (# not insti					9b. CITY,			ON OF DE	EATH			NTY OF D			
		CARRIAGE HILL BETHESDA BETHESDA MONTGOMERY RESIDENCE OF DECEDENT														
	10e. STATE							ION						10d. INSIDE CI	ITY	
Ì	Maryland	Mont	gomery	Wh	eaton							LIMITS?	б но			
	10e. STREET AND NUMBER		101	ZIP COD							?					
	14120 Burnin	g Bus												ted States		
	11. MARITAL STATUS 1 Never Married 2 M	11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. FORCES? 1 YES 2				ARMED 13. WAS DECENDENT OF HISPAN If yes, specify Cuben, Mexica						NIC ORIGIN? (Specify Yes or No— 14. RACE — Am an, Puerto Rican, atc.)				
	3 Widowed 4 Divorc		IF YES, GIVE V	WAR OR DATE	DATES 1 YES 2 NO Specify					r: Spec				». hite		
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	Elementary/Secondary (0-1)	(Specify only highest grade completed) y/Secondary (0-12) College (1-4 or 8 +)			(Give kind of the Do NOT us	work done du se retired.)	iring mo	st of workin	ng							
		12 Homemake:									Own H	ome				
	17. FATHER'S NAME (First, Mide										Middle, Maiden	Sumame)				
l		dberg				Augusta Cohen										
۱	190. INFORMANT'S NAME (Type								er or Rural Route Number, City or Town, State, Zip Code)							
Ì	Joyce H. Kal							_	1 Lai	_	Wheat					
	20e. METHOD OF DISPOSITION 1 Buriel 2 Cremetion	3 🗆 Remo	rval from State	20b. PI carpets	LACE AND DATE (Iry, crematory or o I CS apeal	OF DISPOSIT	ION (Na	me of		DAT		CATION —				
H	4 Donation 6 Other (S 21. SIGNATURE OF FUNERAL S		ENSEE	<u> </u>	iesapeai			D ADDRES	DE OF EA		4 ReT	tsv1.	sville, Maryland			
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I	IMMEDIATE CAUSE (Final disease or condition		CARDIAC ARREST										nd Desth			
	resulting in death)		DUE TO (OR AS A CONSEQUENCE OF):													
			. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE 20+4								+ 400.					
	Sequentially list conditions, if any, leading to immediate DUE TO (OR AS A CONSCOUENCE OF):											Jan.				
	cause. Enter UNDERLYING	se. Enter UNDERLYING														
that initiated events DUE TO (OR AS A CONSEQUENCE OF): resulting in death) LAST																
	resulting in death) LAST	٥	l													
I	PART II. Other algnificant	conditions	contributing to	death but	npt resulting	In the und	erlying	cause g	lven in	Pert I.	24a, WAS AN	AUTOPSY	24b	. WERE AUTOPSY	FINDINGS	
ı	SENILE	DEM	ENTIA								PERFORMED?			AMILABLE PRIOR TO COMPLETION OF CAUSE		
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 Inpatient 2 ER/Outpatient 3 DOA OTHER: 1 Inpatient 2 ER/Outpatient 3 DOA OTHER: 1 Natural 5 Pending Investigation 26b. TIME OF INJURY AT WORK? 27. MANNER OF DEATH 28c. DATE OF INJURY MORK? 28d. DESCRIBE HOW INJURY OCCURI								1 153 2	/ / /		OF DEATH?	VNO				
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								CRIBE HOW I	W INJURY OCCURED							
ı		ould not be								26f. LOCATION (Street and Number or Rural Route Number, City or Town, State)						
ŀ	29e. CERTIFIER															
1 Check only one 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the Hme, date end place, end due to the cause(e) end manner as one 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the Hme, date end place, end due to the cause(e) end manner as one 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the Hme, date end place, end due to the cause(e) end manner as one 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the Hme, date end place, end due to the cause(e) end manner as one 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the Hme, date end place, end due to the cause(e) end manner as one 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the Hme, date end place, end due to the cause(e) end manner as one 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the Hme, date end place, end due to the cause(e) end manner as one 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the Hme, date end place, end due to the cause(e) end manner as one 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the Hme, date end place, end due to the cause(e) end manner as one 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the Hme, date end place, end due to the cause(e)																
Ш		A		camination e	nd/or investigatio	n, in my opi	nlon, de	eth occur	ed at the	time, date	and place, an	d due to th	e cause(s) and manner ee	stated.	
1	290. SIGNATURE AND TIPLE OF CHATIFIER						29c. LICENSE NUMBI				BER 29d. DATE SI		E SIGNED	GNED (Month, Day, Year)		
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	30 NAME AND COUNTY	an	W)	MD	I OWEN CO.			02	65			De	cemb	er 4, :	1995	
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	1 - STATE OF MARYS			TMENT				MENTAL HYGIE					
119	1. DECEDENT'S NAME (First, Middle, Last)							2. DATE OF DEATH		-	3. TIME OF DE	ATH	
	Catherine MARY Ric	ppar	d					November	DAY 77	1995	5:05	P.M.H	
13	4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE	(In yrs. last b	oirthday)	IF UNDER	1 YEAR	IF UNDER	R 24 HRS.	Z. DATE OF BIRTH	8. BIRTI	NPLACE (State or	Fornian		
ļ	311 32 3337				MONTHS DAYS HOURS MIN.			Nov. 17, 1903			Wash.,D.C.		
~	9a. FACILITY NAME (If not institution, give street and number)	9b. CITY, TOWN OR LOCATION OF DEATN					9c. COUNTY OF DEATN						
<u>ö</u>	Suburban Hospital	Beth	nesd.	a			Montgomery						
ក្ខ	RESIDENCE OF DECEDENT 100. STATE 10b. COUNTY	Y, TOWN O	RIOCAT	ION			10d. INSIDE CITY						
DIRECTOR	Maryland Montgomery		hevy					LIMITS?					
A	10e. STREET AND NUMBER				101	ZIP COD	E		10g. CITIZEN OF WHAT COUNTRY?				
E	8100 Connecticut Avenue					20	815		U.S.A.				
BY FUNERAL	11. MARITAL STATUS 1 Never Married 2 Merried FORCES? 1 YES IF YES, GIVE WAR OR (1	WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No— If yee, specify Cuben, Mexican, Puerto Rican, etc.) 1 YES 2 NO Specify: White						dlan,			
	15. DECEDENT'S EDUCATION	16a. DECE	EDENT'S	USUAL OC	CUPATIO	N.		16b. KIND OF	IND OF BUSINESS/INDUSTRY				
COMPLETED	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5 +) 5-+	College (1-4 or 5+) iiie. Do NOT a					ng	high school/educat			uantion		
M	17. FATNER'S NAME (First, Middle, Last)	SCII	COL	Leac	.Her	40. 1407	MEDIC MA			_	ucation	_	
BE CC	17. FATNER'S NAME (First, Middle, Lest) George D. Lantel Katherine Berckmann												
2	196. INFORMANT'S NAME (Type/Print) 196. MAILING ADDRESS (Street end Number or Rural Route Number, City or Town, State, Zip Code)												
F	Mary McLaughlin 8100 Conn., Ave., #824, Chevy Chase, Md. 20815												
	20e. METNOD OF DISPOSITION 1 Burlel 2 Condition 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION / Name of completery, crematory or other place) Metropolitan Crematory Nov. 28,95 Alexandria, Va.												
	4 Donellon 5 Other (Specify) Metropolitan Crematory Nov. 28,95 Alexandria, Va. 21. SIGNATURE OF FUNERAL SERVICE LICENSEE												
	· John F. Dillal	DeVol Funeral Home 2222 Wisconsin Ave., N.W., Wash., DC 20007											
	23. PANY . Enter the diseases, or complications that cause	ed the deel	h Do r	ZZ	the mo	WISCO	ons I	n Ave., N.	w., wa	ısı,	Approxi		
	shock, or heart fellure. List only one couse on IMMEDIATE CAUSE (Final	eech line.	1.4	iot enter	110	de or dy	1	in as cardiac of te	+ i	irest,	Interval	Between nd Death	
	disease or condition resulting in death) a. Afficile Myperided Aussifficency										20	1.	
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ERTIFICATION	Sequentially list conditions, Due TO (OR AB A CONSEqUENCE OF)											m.	
Ē	If any, leading to immediate												
0	CAUSE (Disease or Injury												
H	thet initieted events DUE TO (OR AS A CONSEQUENCE OF): reaulting in death) LAST												
	d.												
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ż	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO DUNCERTAIN												
N.	25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATN (Check only one)												
S	EXAMINER? HOSPITAL: OTHER: OTHER:												
PHYSICIAN: MEDICAL	27. MANNER OF SEATH 260. DATE OF INJURY 26b. TIME OF 26c. INJURY AT 28d. DESCRIBE HOW INJURY OCCURED												
	1 Netural 5 Pending (Month, Day, Year)		IN.	JURY M.		RK7 YES 2	NO						
BY	2 Accident Investigation												

28f. LOCATION (Street end Number or Rural Route Number City or Town, State)

ERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, date end placa, end due to the cause(e) end menner ee stated.

29b, SIGNATURE AND STILE OF CONTUR

D IPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

Fitzgerald, M.D., 8218 Wisconsin Ave., Bethesda, Md. 20814

1995

July Devilor Resistrates Signature

1995 Blaine

DEC 05 1995

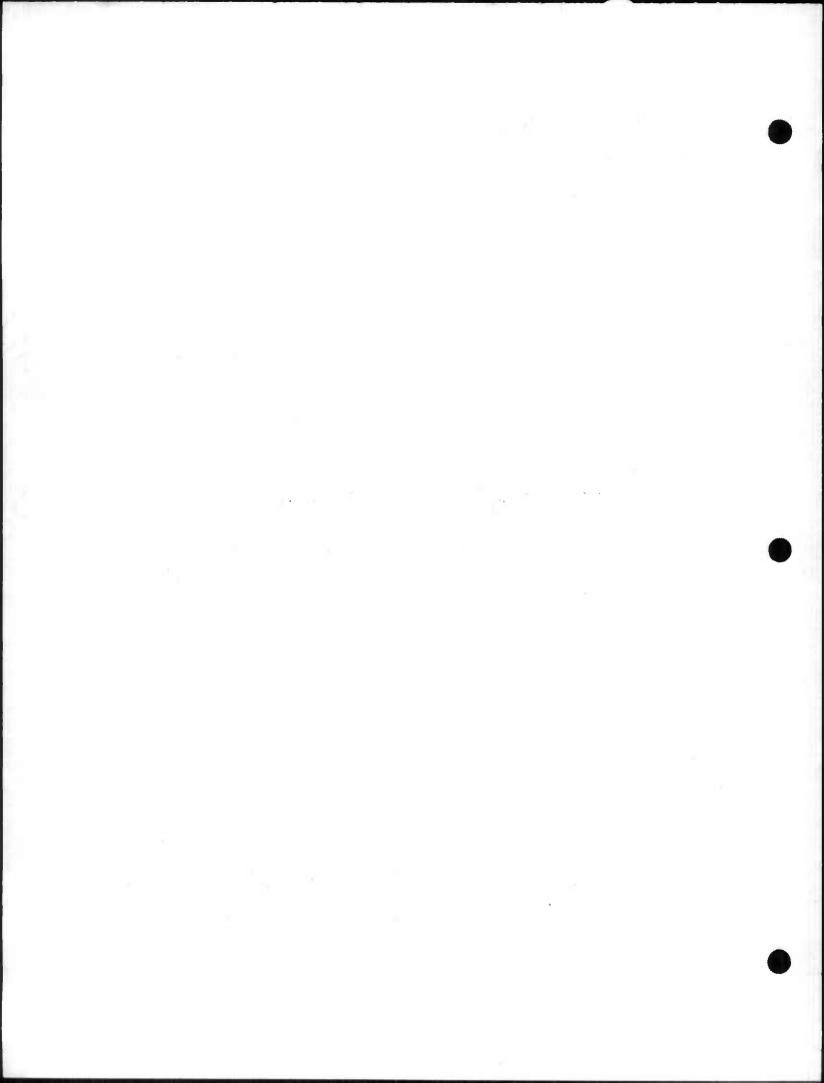
1 Netural
2 Accident
3 Suicide

4 Nomicide

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MARYLAND 21215-0020

FOR STATE REGISTRAR

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DIVISION OF VITAL RECORDS, P.O. BOX 68/60	0	ā
	THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may	THE CHARDAL DIRECTOR: After this cardificate has been comed by the attendion physician and completely filled in by the funeral director has
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9e. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH DIRECTOR Shady Grove Adventist Hospital Rockville 10e. STATE 10b. COUNTY IRC CITY TOWN OR LOCATION Maryland Montgomery Rockville permit. 10e. STREET AND NUMBER FUNERAL 101, ZIP CODE burial-transit 14701 Pommel Drive 20850 retained by the hospital or attending physician. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ∑ YES 2 NO IF YES, GIVE WAR OR DATES If yes, specify Cuban, Mexicen, Puerto Ricen, etc.)

1 YES 2 NO Specify: t Never Merried 2 Married BY 3 Widowed 4 Divorced use as the 1969-1974 ETED 16e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 15. DECEDENT'S EDUCATION (Spr 10 Elementary/Secondary (0-12) College (1-4 or 5+) COMPL 4 Marketing Manager 17. FATHER'S NAME (First, Middle, Lest) 2 Robert W. Rabuck, Sr. BE Ruby Underkoffler Should notified 19a. INFORMANT'S NAME (Type/Print) 2 Patricia A. Rabuck pe 20a. METHOD OF DISPOSITION
1 X Burial 2 Cremation 3 Re 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) December 1, Gate of Heaven Cemetery 1995 must 4 Donation 6 Other (Specify) . examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE M00831 bmomu * Darbara medical 0 IMMEDIATE CAUSE (Final the CARCINOMA OF THE RECTUM cremation. disease or condition_ TASTATIC resulting in deeth) event, DUE TO (OR AS A CONSEQUENCE OF) burial. other traumatic CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate cause. Enter UNDERLYING prior CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 0 Mental Injury. PART II. Other significent conditions contributing to deeth but not reaulting in the underlying cause given in Part i. MEDICAL and PERFORMED? any MULTIPLE SCLEROSIS 1 - YES 2 NO Health Shows 6 DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO W UNCERTAIN PHYSICIAN: 23 28. PLACE OF DEATH (Check only one 25. WAS CASE REFERRED TO MEDICAL EXAMINER? State HOSPITAL:
1-A inpatient 2 - ER/Outpatient 3 - DOA 4 Nursing Home 5 Residence 6 Other (Specify) 10 the 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? marked, with 1 X Natural 5 Pending 1 YES 2 NO ВҮ death 2 Accident 28e. PLACE OF INJURY — At home, term, street, fectory, office building, etc. (Specify) 3 Suicide 99 COMPLETED 8 Could not be after 28 4 Homicide hours ltem. 1 P TO THE HOSPITY
TO THE FUNERA
Be filed within 7
IMPORTANT: I 29c. LICENSE NUMBER 13 Delly 2 9707 MEDICAN MM 4WG 32 REGISTRAR & SIGNATURE 31. DATE FILED (Month, Day, Year) 04 1995

1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH 1995 DAY November 28, Robert 11:59 PM Rabuck 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year) 8. BIRTHPLACE (State or Foreign HOURS 1 🔀 M 2 🗌 F YRS. 214-46-9382 50 March 13, 1945 Maryland 9c. COUNTY OF DEATH Montgomery 10d. INSIDE CITY 1 K YES 2 NO 10g. CITIZEN OF WHAT COUNTRY? United States 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian. Black, White, etc. White 16b. KIND OF BUSINESS/INDUSTRY Telecommunications 18. MOTHER'S NAME (First, Middle, Maiden Surname) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14701 Pommel Drive, Rockville, Maryland 20850 20c. LOCATION - City or Town, State Silver Spring, Maryland Robert A. Pumphrey Funeral Home/ Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardisc or respiratory arrest, shock, or heart failure. List only one ceuse on each line. Interval Between Onset and Death 5 YRS 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO 28d. DESCRIBE HOW INJURY OCCURED 28t. LOCATION (Street and Number or Rural Route Number, City or Town: State) 29e. CERTIFIER (Check only one)

The physician: To the best of my knowledge, dash occurred at the time, date and place, and due to the cause(s) and manner se stated. 2 MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(e) and menner se stated 29d. DATE SIGNED (Month, Day, Year) MOVEMBER 29

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

FOR STATE REGISTRAR

4. SOCIAL SECURITY NUMBER

1. DECEDENT'S NAME (First, Middle, Last)

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030-01-6549 1 🗌 M 2 💢 F 79 permit. Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH SHADY GROVE ADVENTIST HOSPITAL DIRECTOR ROCKVILLE RESIDENCE OF DECEDENT 10a. STATE 10b. COUNT 10c. CITY, TOWN OR LOCATION MARYLAND MONTGOMERY SILVER SPRING FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE **422 LEGATO TERRACE** funeral director, page 5 should be detached for use as the burial-transit 20901 retained by the hospital or attending physician. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-1 Never Married 2 Married If yes, specify Cuben, Maxican, Puerto Rican, etc.)

1 YES 2 NO Specify: BY 3 X Widowed 4 Divorced COMPLETED 18a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working 15. DECEDENT'S EDUCATION (Specify only highest grade complete (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) SECRETARY/CLERK once. 17. FATHER'S NAME (First, Middle, Lest) MAIER COE Ħ notified 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 STEVE ROBINS (SON) hours after death. Page 6 may be pe 20g, METHOD OF DEPOSITION 1 X Burial 2 Committee must l KING DAVID MEMORIAL GARDEN 12/4 4 Donation Other (Specify) HERME SERVICE LIC examiner 21. SIGNATUR completely filled in by the ial, cremation, or removal. medicai 23. PART I. Inter the diseases, of complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of higher fellure. List only one cause on each line. IMMEDIATE CAUSE (Final the disease or condition_ Cardiopuluonary arrest with deoth resulting in death) executed within traumatic event, heart failure burial. CERTIFICATION and Sequantially list conditions, the attending physician a Mental Hygiene prior to If any, leading to immediate cause. Enter UNDERLYING OR ATTENDING PHYSICIAN: The law requires that the death certificate be Mag or De DUE TO OR AS A CONSEQUENCE OF other t CAUSE (Disease or injury that initiated events resulting in death) LAST 6 injury, PART II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. MEDICAL a de any this certificate has been signed with the State Dept. of Health a Shows DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) Item FIOSPITAL:
t | Inpatient 2 | ER/Outpatient 3 | DOA EXAMINER? OTHER:
4 | Nursing Home 5 | Rasidence 8 | Other (Specify) 6 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 1 Natural marked, 5 Pending Investigation 1 YES 2 NO E FUNERAL DIRECTOR: After this within 72 hours after death w RTANT: If Item 28 is mark BY Accident 28a. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify) 3 Suicide COMPLETED 4 Homicide 29a. CERTIFIER
(Check only CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as attend. HOSPITAL TO THE HOSPITA
TO THE FUNERAL
DE filed within 72
IMPORTANT: II 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(a) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER BE 23170 2 SEORGETOWN

04 1995

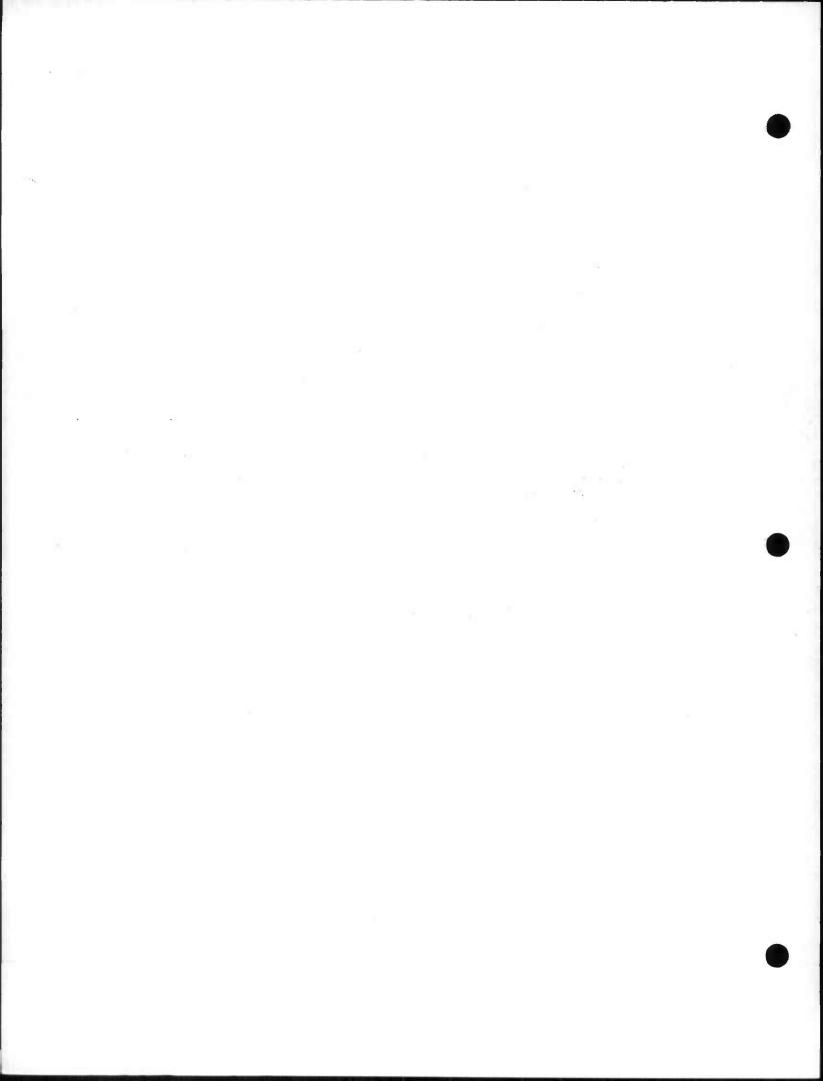
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6. AGE (In yrs last birthday)

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO 2. DATE OF DEATH MONTH DAY 3. TIME OF DEATH YEAR 1806 December 01 1995 PM IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign DEC. 16, MASSACHUSETTS 1915 9c. COUNTY OF GEATH MONTGOMERY 10d. INSIDE CITY VES 2 NO 10g. CITIZEN OF WHAT COUNTRY? UNITED STATES 14. RACE — American Indian, Black, White, etc. Spec#y: WHITE 16b. KIND OF BUSINESS/INDUSTRY UNITED STATES GOVERNMENT te. MOTHER'S NAME (First, Middle, Maiden Surname) HANNA SORKIN P.O. BOX 4265 - SILVER SPRING, MARYLAND 20914 20c. LOCATION — City or Town, Stata FALLS CHURCH, VIRGINIA 22. NAME AND ADDRESS OF FACILITY DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 1170 ROCKVILLE PIKE-ROCKVILLE, MARYLAND 20852 Approximata Onset and Death minutes plars 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS PERFORMED? AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO 1 TYES 2 NO 28d. DESCRIBE HOW INJURY OCCURED 281. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29d. DATE SIGNED (Month, Day, Year)

December 03.1995



YEAR

1995

3. TIME OF DEATH

11:53 P

REG. NO

2. DATE OF DEATH

December

STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

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4. SOCIAL SECURITY NUMBER 5 SEX 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH (Month, Day, Year) IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign 1 M 2 X F Dec. 14, 215-38-3838 94 1900 Pennsylvania Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Manor Care Nursing Home Silver Spring Montgomery RESIDENCE OF DECEDENT 10c, CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Laurel 1 TYES 2 X NO Howard permit. FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 20723 the burial-transit 11333 Harding Road United States retained by the hospital or attending physician. 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or NoIf yes, specify Cuben, Maxican, Puerto Rican, stc.)

1 YES 2 NO Specify: 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 14. RACE - American Indian, Black, White, etc. FORCES? 1 YES 2
IF YES, GIVE WAR OR DATES 1 Never Married 2 Married Specify BY 3

Widowed 4 □ Divorced White 38 ETED 15. DECEDENT'S EDUCATION 18s. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY USe (Specify only highest t of working (Give kind of work done life. Do NOT use retired.) jo College (1-4 or 5+) Elementary/Secondary (0-12) COMPL Homemaker page 5 should be detached 12 Home Once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Ħ Jacob Butker BE Anna Stritzel notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 11333 Harding Road, Laurel, Maryland 20723 Marianne R. Dortch within 24 hours after death. Page 6 may be 90 20s. METHOD OF DISPOSITION
1 N Burisl 2 Cremetton 3 Removal from State
4 Donatton 5 Other (Specify) 20c. LOCATION -- City or Town, State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE director, p must George Washington Cemetery12/4 Adelphi, Maryland medital syaminer 21. SIGNATURE OF FUNERAL SERVICE LINERS EN 22. NAME AND ADDRESS OF FACILITY funeral Hines-Rinaldi Funeral Home, Inc. rober 11800 New Hampshire Ave., Silver Spring, MD 9 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, auch as cerdiec or respiratory strest, shock, or heert failure. Liet only one cause on each line. filled in by I Approximate Interval Between ō IMMEDIATE CAUSE (Final **Onset and Death** the cremation. diseese or condition Myocardial hours completely resulting in desth) traumatic event, DUE TO (OR AS A CONSEQUENCE OF) burial, executed themic CERTIFICATION and Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF) the attending physician a Mental Hygiene prior to If sny, leeding to immediate cause. Enter UNDERLYING Bleeding 2 Gastrointestind certificate other t CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in desth) LAST 0 the death injury, PART II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS MEDICAL been signed by th AVAILABLE PRIOR TO shows any COMPLETION OF CAUSE 1 TES 2 NO OF DEATH? 1 TYES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO W UNCERTAIN PHYSICIAN: this certificate has be with the State Dept. M. 23 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one, ATTENDING PHYSICIAN: The Item EXAMINER? HOSPITAL: OTHER: 1 [] Inpetient 2 [ER/Outpetient 3 [DOA 10 27. MANNER OF DEATH 26a. DATE OF INJURY (Month, Day, Year) 26b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED Is marked, 1 Natural 5 Pending 1 YES 2 NO DIRECTOR: After the hours after death v BY Investigation 2 Accident 28a. PLACE OF INJURY -- At home, farm, street, factory, office 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined COMPLETED 4 Homicide 28 item OR 29a. CERTIFIER

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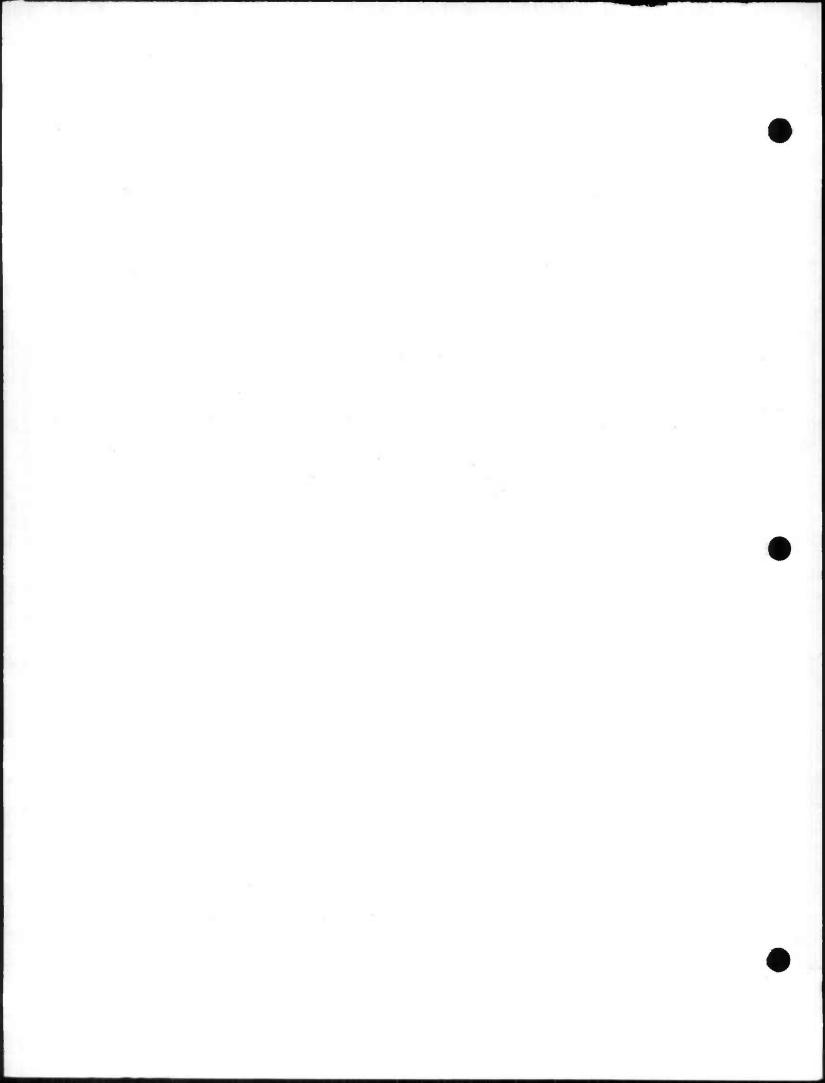
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(C FUNERAL D within 72 h TO THE HOSPITA
TO THE FUNERA
De filed within 72
IMPORTANT. II 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(s) and manner as stated. 29b. SIGNATURE AND TITKE OF CERTIFIER 29c. LICENSE NUMBER 29d, DATE SIGNED (Month, Day, Year) y Mong MD BE December 2nd D43260 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 333 Laurel Bowie Rd # 307 Laurel nny Structur Revoluti DEC 05 1995 DHMH-16 Rev 1/89

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

Kobbins



	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the builat-transit nermit. Pages 1 2 3 should	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: It item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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	1 - FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPAR CERTIF	TMENT OF H	IEALTH AND I	MENTAL HYGIEI		00103
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH		3. TIME OF DEATH
		Martha G. Re	imer			December	5. 1995	
	4. SOCIAL SECURITY NUMBER		In yrs. lest birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)	0. Bit	RTHPLACE (State or Foreign
	117-10-3649		6 YRS.	MONTHS DAYS	HOURS MIN.	Nov. 18,		New York
œ	9a. FACILITY NAME (If not institution, give a Manor Care—Pot				OR LOCATION OF DE	ATH	9c. COUNTY O	
DIRECTOR	RESIDENCE OF DECEDENT			PO	tomac		Mont	gomery
EC.	10e. STATE 10b. COUNTY	1	10c. CIT	Y, TOWN OR LOCAT	ION			10d, INSIDE CITY
	Maryland Mont	gomery		Potoma	2			1 YES 2 NO
3AL	10e. STREET AND NUMBER			101	ZIP CODE		10g. CITIZEN O	F WHAT COUNTRY?
FUNERAL	10714 Potomac Ter				20854			d States
	11. MARITAL STATUS 1 Never Married 2 Married	12. WAS DECEDENT EVER IN FORCES? 1 YES	2 XNO	If yes, sp	ecify Cuban, Maxican	IIC ORIGIN? (Specify Yen, Puerto Rican, atc.)	s or No- 14. R. B	ACE — American Indian, lack, White, atc.
BY	3 Wildowed 4 Divorced	IF YES, GIVE WAR OR DA	ATES	1 🗆 YES	2 XNO Specify	r.	Sį	White
COMPLETED	15. DECEDENT'S EDUC (Specify only highest grade	CATION	16a. DECEDENT'S	USUAL OCCUPATION CONTROL OCCUPAT	ON	16b. KIND OF BU	SINESS/INDUSTR	γ
LET	Elementary/Secondary (0-12)	College (1-4 or 5 +)	Ille. Do NOT us	e retired.)				
MP	10		Files S	upervis			urance	
	17. FATHER'S NAME (First, Middle, Last)					ME (First, Middle, Maider	Sumame)	
BE	August D.F. Meye	er .	105 11411 1110	4000000 (O)		thea Eck		
5	Ruth R. Allenspa	ich	1			Route Number, City or Tow Comac, Mar		20854
	20s. METHOD OF DISPOSITION	20b.	PLACE AND DATE O	F DISPOSITION (A)	me of O 1.0		CATION — City or	
	1 1 Burial 2 Cremation 3 Remo	ovel from State cem	etery, cremetory or of laple Gro	ve Ceme	ec. 8, 19 tery	Kew		s, New York
ĺ	21. SIGNATURE DE FUNERAL SERVICE LIC	ENSEE		22. NAME AN	D ADDRESS OF FAC	Shroy Fune	ral Home	o /Pockwillo
	Kalufto	ench M	100198	300,1	Vest Mont	gomery Ay	enue	e/Rockv <u>ille</u> , Inc.
	23. PART i. Enter the diseases, or c	complications that caused List only one cause on as	tha death. Do n	ot antar the mo	de of dying, auch	n as cardiac or reap	iratory arreat,	Approximate
	IMMEDIATE CAUSE (Final	SE SECTION STATES						Interval Between Onset and Death
	disease or condition resulting in death)	0	oscleros					
_	DUE TO (OR AS A CONSEQUENCE OF):							
o	Sequentially list conditions,	DUE TO (OR AS A	CONSEQUENCE OF):				
S	cause. Enter UNDERLYING CAUSE (Disease or injury	<u>.</u>						
E	that initiated events resulting in death) LAST	DUE TO (OR AS A	CONSEQUENCE OF):				
CERTIFICATION	resulting in death) Exist	i						
4	PART II. Other aignificant conditions	a contributing to death be	ut not resulting i	n tha undarlying	cause given in I			4b. WERE AUTOPSY FINDINGS
PHYSICIAN: MEDIC						PERFO	0.00	OF DEATH?
ME							<i>x</i>	1 ☐ YES 2 ☑ NO
AN	DID TOBACCO USE CONTR				UNCERTAIN	1 🗆		
Sign	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	HOSPITAL:	26. PLACE OF DEAT	OTHER:				
H	27. MANNER OF DEATH	1 ☐ Inpatient 2 ☐ ER/Outp	26b. TIME		5 Residence (8 ☐ Other (Specify) 28d. DESCRIBE HOW	MILIBY OCCURED	
ВУР	1 Natural 5 Pending 2 Accident Investigation	(Month, Dey, Year)	ILMI	JRY WO	RK? ES 2 NO		JINOTH COCCINED	
	3 Suicide 8 Could not be	28e. PLACE OF INJURY building, atc. (Speci	— At home, farm, s	treet, factory, office		281. LOCATION (Street	and Number or Run	ni Route Number,
COMPLETED	4 Homicide determined					City or Town, State,		
PL		CIAN: To the best of my knowle						
Ö	2 MEDICAL EXAMINE	R: On the basis of examination	and/or investigation	n, in my opinion, de	eath occured at the t	time, data and place, er	nd due to the caus	e(s) and manner as stated.
BE (296. SHONATURE AND TITLE OF CERTIFIER	11 11	1 4		29c. LICENSE NUM	BER /		EO (Month, Day, Year)
6	20 HAME AND ADDRESS OF THE PARTY OF THE PART		-0		0200) / 0	▶ Dec.	5, 1995
	Joel R. Schulma			die	n Road 1	Bethesda,	Marulan	d 20814
1	31. DATE FILEO (Month, Day, Year)	22. REGISTRAR'S SIGNA		TOTRETOW	ii Nodu,	bernesua,	Harytall	20014
	DEC 07 1995	Java Dander	C. Salar					
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Albert Marie

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

FOR 1 - STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

	nedio I nan		OL.		CAIL	- 01	DEC	111	r	TEG. NO.			
	1. DECEDENT'S NAME (First, Middle, Last)	Martin James Ryan								2. DATE OF DEATH DAY YEAR December 3, 1995			3. TIME OF DEATH 4:45 PM
	4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday)							7. DATE OF		3, 1			
	128-14-5356	1 M 2 F	6. AGE (III YIS. INS	YRS.	MONTHS	DAYS	HOURS	MIN,	(Month, Day, Year) May 6, 192		27	8. BIRTHPLACE (State or Foreign Country) New York	
	9a. FACILITY NAME (If not institution, give :	street and number)			Dh. CITY	TOWN (OR LOCATI	ON OF DE		, 10	9c. COUN		
œ	15115 Interlachen Drive #618						r Sp						
2	RESIDENCE OF DECEDENT	DIIVE #	010		5.	TTAE	er sp	TING			MOI	tgor	пету
E E	10a. STATE 10b. COUNT	Y		10c. CITY	Y, TOWN O	R LOCA	TION						10d. INSIDE CITY
DIRECTOR	Maryland Mon	tgomery		S	ilve	r Sp	ring						LIMITS?
7	10e. STREET AND NUMBER					10	. ZIP COD	E			10g. CITIZ	EN OF W	HAT COUNTRY?
ER/	15115 Interlache	n Drive,	#618				209	06			Uni	ited	States
BY FUNERAL	11, MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced		T EVER IN U.S. AR YES 2 1		1	f yes, sp		n, Mexica	HIC ORIGIN? (S in, Puerto Rice y:		or No-	14, RACE Black Specifi	
	3 Wildowed 4 Bistotes	1944-19	45										White
COMPLETED	15. DECEDENT'S EDU (Specify only highest grade		(G	CEDENT'S	work done o			ng	16b, KII	ND OF BU	SINESS/IND	USTRY	
E I	Elementary/Secondary (0-12)	College (1-4 or 5	⊦) life.	. Do NOT us	se retired.)								
d l		5+	Se	elf-Er	mp1o	yed			Co	omput	er Ut	ilit	ties
ō	17. FATHER'S NAME (First, Middle, Last)						18. MOT	NER'S NA	ME (First, Midd	Ne, Maiden	Surname)		
Ш	Martin Joseph F	Ryan					Ma	ry C	atheri	ine C	ampbe	211	
BE	19a. INFORMANT'S NAME (Type/Print)	-	19	b. MAILING	ADDRESS	S (Street a	and Numbe	r or Rural	Route Number,	City or Tow	n, State, Zip	Code)	
5	Sheila A. Ryan		1	5115	Inte	erla	chen	Dr.	#618.	Silv	er Sr	orino	g,MD 20906
	20a. METHOD OF DISPOSITION						_			7	CATION —		
	1 Burial 2 Cremation 3 Ran 4 Donation 5 Other (Specify)		206. PLACE of cemetery, cre Gate	of F	leave	en C	emet	ery		Sil	ver S	prin	ng, Maryland
	21. SIGNATURE OF PUNERAL SERVICE U	Cegnee /_	мо	0198	²² Re	ober 300	t A. West	Pun Pun Mon	ciury iphrey itgomei larylar	Fune	eral E	lome,	/Rockville,
	23. PART i. Enter the diseases, or												
	ahock, or haart fallure. IMMEDIATE CAUSE (Final disease or condition resulting in death)	A list made and construction											Approximate Interval Batween Onset and Death
TION	Sequentially list conditions, if any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF):												
CERTIFICATION	CAUSE (Disease or injury that initiated events DUE TO (OR AS A CONSEQUENCE OF):												
E	resulting in death) LAST	d											
		SIP - A SECTION											
EDICAL	PART ii. Other aignificant condition	Narch	death but not	reauiting	in the ur	nderlyin	ig cause	given in	Part I. 24	PERFO	AUTOPSY RMED?	246.	. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO
50	- Krazec	racin	res						1	YES :	THO		OF DEATH?
ME													1 YES 2 410
	DID TOBACCO USE CONT	RIBUTE TO CA	USE OF DEA	ATH YE	ES 🔲 I	NO [JUNO	CERTAI	N 🗆				
A	25. WAS CASE REFERRED TO MEDICAL			CE OF DEAT		-							
SIC	EXAMINER?	HOSPITAL:	ER/Outpetlant 3	1 DOA	OTHE!		no 5 (7)4	anidanca	6 Other (S	Page/6/1			
PHYSICIAN:	27. MANNEY OF DEATN	28e, DATE OF		28b. TIM			JURY AT	ENGELICE	28d. DESCR		INJURY OCC	CUBED	
>	1 Natural 5 Pending 2 Accident Investigation		Day, Year)		M	W	YES 2	NO	200. 02001			701120	
red 8	3 Sulcide 8 Could not be determined		OF INJURY — At he , etc. (Specify)	ome, farm,	street, faci	tory, offi	Ce			ON (Street Town, State		or Rural F	Route Number,
H	29a. CERTIFIER	war sa en				. In the		Selv 2			AN INC.		
COMPLETED	29s. CERTIFFIER (Check only one) 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.												
BE	296. SIGNATURE AND TITLE OF CERTIFIE	my mil	her	a,),	n. D).	29c. LIC	ENSE NU	MBER 7	5		SIGNED	Month Day, Year)
5	30. NAME AND ADDRESS OF PERSON W	NO COMPLETED CAL	ISE OF OEATH (ITE	M 27) (Tuna	Print)						1	/ /	1
	Catherine M. Ch					iona	al Dr	ive,	Silve	er Sp	ring	, MD	20906
	31. DATE FILED (Month, Day, Year)		AR'S SIGNATURE										
	DEC 07 1995	Jalin Da	viction-Rand	64									

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2. 3 should be find within 72 hours after death with the State Dest of Health and Mental Hotelete prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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	1 - FOR STATE REGISTRAR	STATE OF MARYLA	ND / DEPARTM			MENTAL HYGIEN	E		
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH			3. TIME OF DEATH
	Gladys M. Sh.	ahan				Nov. 23	1995	YEAR	9:05 PM M
	4. SOCIAL SECURITY NUMBER 5.	SEX 6. AGE (II		UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH		S. BIRTHE	PLACE (State or Foreign
	056 42 6814 1 [5 YRS.	NTHS DAYS	R LOCATION OF DE	Feb. 20,1		Wisc	onsin
DIRECTOR	Meridian Health Ca			nnapol:					ınde1
EC	10a. STATE 10b. COUNTY		10c. CITY, TO	OWN OR LOCAT	ION				10d. INSIDE CITY LIMITS?
	Maryland Montgo	mery	Che	vy Cha	se				YES 2 NO
FUNERAL	10e. STREET AND NUMBER		"	101.	ZIP CODE				HAT COUNTRY?
Ë I	8100 Connecticut A				20815				States
BY FUI	11. MARITAL STATUS 1 □ Never Merried 2 □ Merried 3 ☑ Widowed 4 □ Divorced	WAS DECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR DA	5XXNO	Il yes, spe		IC ORIGIN? (Specify Yes n, Puerto Ricen, etc.)	or No-	14. RACE Black, Specify	- American Indian, White, atc. White
	15. DECEDENT'S EDUCATION	ON I	16e. DECEDENT'S USU	JAL OCCUPATION	N	16b, KIND OF BUS	SINESS/IND	USTRY	
COMPLETED	(Specify only highest grade comp	pleted) otlege (1-4 or 5 +)	(Give kind of work life. Do NOT use re	done during mo- tired.)	st of working				1991
17	12		Homemake	r		Own H	ome		
Ö	17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NA	ME (First. Middle, Meiden	Surname)		
BE	Eugene J. Mattison				Anna	Marie	Rachu	ıt	100 300
TO E	19e. INFORMANT'S NAME (Type/Print)					Route Number, City or Tow			
-	Marguerite M. Matt	ison	12802	Buckin	gham Dri	ve Bowie			20715
	20s. METHOD OF DISPOSITION 1	1rom State 20b.	PLACE AND DATE OF D etery, crematory or other etropolita	esposition (Na place) Crem	atory 11	/26/95 A1	exand	ony or Tow Iria	_{rn, State} Virginia
	21. SIGNAL PUNERAL SERVICE LICENS	EE	0	22. NAME AN	D ADDRESS OF FA	ans Funera			
	- Kawar (CITIMO	Mes			lis Rd. Bo			
	23. PART I. Enter the diseases, or com	plications that caused	the death. Do not						Approximate
	ahock, or heart fellure. List IMMEDIATE CAUSE (Final disease or condition	only one cause on as	ich line.	+1					Onset and Dauth
	resulting in death) - a. Vualley Death								motorie.
N	Sequentially list conditions, I have a consciouence of:								
CERTIFICATION	If any, leading to immediate cause. Enter UNDERLYING	QUE TO (DR AS A	CONSEQUENCE OF):	20 6	I fibillation				Ven
FIC	CAUSE (Disease or injury that initiated events	DUE TO (OR AS A	CONSEQUENCE OF):	4		(0-1			- Kar
E	reaulting in death) LAST			1					
	Party ii. Other algnificant conditionalco			h a dada	f	n		Lau	
SAL	M. A. S. T. T. VILLE	ontributing to death a	1 / h he			# DEDECT		240.	WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE
MEDIC	1 W10 W3 01 -0142	3 11 acc	2 office	ue o	r. aya	1 - YES 2	KNO		OF DEATH?
M	DID TODACCO LICE CONTRIBU	LITE TO CALLEE O	E DEATH VEC		1 LINICEDTAIN		,		1 YES 2 NO
PHYSICIAN:	DID TOBACCO USE CONTRIB 25. WAS CASE REFERRED TO MEDICAL		26. PLACE OF DEATH		UNCERTAIN	YEN			
S	EXAMINER?	OSPITAL: Inpetient 2 ER/Outp	_ 0	THER:					
H	27. MANNER QE DEATH	26e. DATE OF INJURY	266. TIME O			6 Other (Specify) 28d. DESCRIBE HOW	NJURY OC	CURED	
	1 Natural 5 Pending	(Month, Dey, Year)	INJUR	Y WO	RK?	_			
BY	2 Accident Investigation 3 Suicide 6 Could not be	26e. PLACE OF INJURY	- At home, ferm, stre	et, fectory, offic		281. LOCATION (Street		or Rural R	loute Number,
TED	4 Homicide determined	building, etc. (Spec	Hy)			City or Town, State;			
COMPLET	29 CERTIFIER 1 CERTIFYING PHYSICIAN	N: To the best of my know	ledge, death occurred a	at the time date	and place, and due	to the cause(a) and ma	Oner ee stel	ad a	
MP	none orași	on the basis of examination) and manner as stated.
	MONITURE AND FITLE OF CERTIFIER	1			29c. LICENSE NUI	4BER	29d, DAT	E SIGNED	(Month, Day, Year)
BE	YVV	Vi			1) 101	53	1) /	65
2	30. NAME AND ARDITESS OF PERSON WHO CO	OMPLETED CAUSE OF DE	ATH (ITEM 27) (Type, Pri	int)	1	1	14	-1-	
	31. DATE FILED (Month, Day, Year)	www ?	003 has	d. PK	Way	Annag 1:	s k	40	21/0/
	DEC 4 1995	32. TEGISTRAR'S SIGN	rhadell		/ (

NAME OF THE PARTY

lei -

YEAR

1995

9c. COUNTY OF DEATH

3. TIME OF DEATH

BIRTHPLACE (State or Foreign Country)

Maryland

1:20 P

REG. NO.

2. DATE OF DEATH

DECEMBER 1

Aug. 18,1935

7. DATE OF BIRTH (Month, Day, Year,

FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

4. SOCIAL SECURITY NUMBER

218-34-5449

NANCY

9a. FACILITY NAME (If not institution, give street and number)

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permit. Pages 1, 2, 3 should Prince George's Hospital Center DIRECTOR Cheverly, Maryland Prince George's RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Prince George's Riverdale Maryland TXX YES 2 NO 100. STREET AND NUMBER FUNERAL 101. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 20737 United States 6506 51st. Ave. funeral director, page 5 should be detached for use as the burial-transit 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Married If yes, specify Cuban, Mexican, Puerto Rican, etc.) IF YES, GIVE WAR OR DATES t YES 2 TO NO Specify. Specify White BY 3 Wildowed 4 Divorced COMPLETED 15. DECEDENT'S EDUCATION pecify only highest grade complete 16s. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5+) 12 Cashier Retail 17, FATHER'S NAME (First, Middle, Lest) 18. MOTHER'S NAME (First, Middle, Maiden Surname) George Schmidt Elsa Michaels 194. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6506 51st Ave. Riverdale, Md. 20737 Michael W. Smith 90 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State DATE must ☐ Donation 6 ☐ Other (Specify) 12/6 Lincoln Cemetery Brentwood, Maryland examiner 21. SIGNATURE OF FUNERAL SHEET Fort Lincoln Funeral HOme, Inc. 3401 Bladensburg Rd. Brentwood, Md. 20722 signed by the attending physician and completely filled in by the Health and Mental Hygiene prior to burial, cremation, or removal. medical 23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart fellure. List only one cause on each line. **IMMEDIATE CAUSE (Final Onset and Daath** CARCINOMA the OF LUNG disesse or condition resulting in death) 2 MONTHS event. DISEASE CORONARY YEARS other traumatic CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF) If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF) that initiated events reaulting in death) LAST Injury, PART II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I. MEDICAL 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS PERFORMED? AVAILABLE PRIOR TO HYPERLIPIDEMIA REFLUX ESOPHAGITIS shows any COMPLETION OF CAUSE OF DEATH? 1 - YES 2 NO 1 YES 2 NO this certificate has been a with the State Dept. of DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES 🔀 NO 🗌 UNCERTAIN 🗆 PHYSICIAN: 23 26. PLACE OF DEATH (Check only one) 25. WAS CASE REFERRED TO MEDICAL HOSPITAL: EXAMINER? OTHER: 4 - Nursing Home 5 - Residence 8 - Other (Specify) 6 28a. DATE OF INJURY (Month, Day, Year) 27. MANNER OF DEATH 28b. TIME OF marked, 28c. INJURY AT WORK7 26d, DESCRIBE HOW INJURY OCCURED 1 Natural 5 Pending Investigation 1 YES 2 NO BY THE HOSPITAL OR ATTENDING P THE FUNERAL DIRECTOR: After to filed within 72 hours after death to 2 Accident 28s. PLACE OF INJURY — At homs, term, streat, factory, office building, atc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 8 Could not be COMPLETED Item 28 4 Homicide datarmined 29a. CERTIFIER
(Check only one)

CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

MEDICAL EXAMINED: On the best of examination and/or impediately in the place of examination and or impediately in the place of exami TO THE FUNERAL (
De filed within 72 h
IMPORTANT: If II 2 MEDICAL EXAMINER: On the besis of exa ation and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(a) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE 870 0 19897 9 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 20 (TYPO, PHIN))

V. SINGH 7209 A HANOVER PARKWAY CREENBRIT MA

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

> IF UNDER 1 YEAR IF UNDER 24 HRS. HOURS

9b. CITY, TOWN OR LOCATION OF DEATH

DAYS

SMITH

60 YRS.

6. AGE (In yrs. last birthday)

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31. DATE FILED (Month, Day.

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IN THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 sho	is marked,

		<u> </u>	CATE OF	DEATH	REG. NO	•	3. TIME OF DEATH	
John S	Schwaner				December	6. 1995		
4. SOCIAL SECURITY NUMBER		GE (In yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH	_	THPLACE (State or Foreign	
578-09-8728	1 XXM 2 □ F	79 YRS.	MONTHS DAYS	HOURS MIN.	(Month, Day, Your) 4-21-16	0hi	intry)	
9e. FACILITY NAME (If not institution, give			9b. CITY, TOWN O	R LOCATION OF DE		9c. COUNTY OF		
14705 Livingston	n Road		Aco	cokeek		Prince	George's	
Maryland Prin			, TOWN OR LOCAT COKEEK	TON			10d. INSIDE CITY LIMITS? 1 X YES 2 NO	
14705 Livingsto	n Road		101	20607		6 11/11/25	JSA	
11. MARITAL STATUS 1 Never Merried 2 Merried 3 Widowed 4 Divorced	12. WAS DECEDENT EVE FORCES? 1 X Y IF YES, GIVE WAR OF W.W. II	ES 2 NO	If yee, no	ENDENT OF HISPAN scify Cuben, Mexice 2XX NO Specify	HC ORIGIN? (Specify Yar n, Puerto Rican, etc.)	81	White	
15. DECEDENT'S EDI (Specify only highest grade	e completed)	16e. DECEDENT'S (Give kind of w life. Do NOT use	ork done during mo	ON st of working	16b. KIND OF BU	SINESS/INDUSTRY		
Elemantary/Secondary (0-12)	College (1-4 or 5+)	Mai	1er		Washing	ton Star	Newspaper	
17. FATNER'S NAME (First, Middle, Last)		1101		18. MOTHER'S NA	ME (First, Middle, Meiden		. немзрарет	
Fran	k Schwaner				ry Demel	22.0		
19e. INFORMANT'S NAME (Type/Print)	e beliwanci	19b. MAILING	ADDRESS (Street e		Route Number, City or Tow	vn, State, Zip Code)		
John L. Schwan	er	11902	Pitt Dr	ive Fort	t Washingt	on. Md.	20744	
200 METHOD OF DISPOSITION 1 X Purisi 2 Cremation 3 Ran	271	20b. PLACE AND DATE O	F DISPOSITION (No	me of	DATE 20c. LC	CATION — City or	Town, State	
1X) Spuries 2 Cremation 3 Removal from State Commenter, Crematory or other place Vashington Nat'1. Cemetery 12-9-95 Suitland, Maryland								
21. SIGNATURE OF JUNERAL SERVICE U			22. NAME A	D ADDRESS OF FA	CILITY			
1 (A) MT 1 (A) (A)					as Funeral		M1 007/F	
23. PART I. Enter the diseases, or	complications that cau	sed the death. Do n			1 Rd. Oxor		Md. 20745	
ahock, or heert failure. IMMEDIATE CAUSE (Final	List only one ceuse of	n each line.			· ·	, , , , , , , , , , , , , , , , , , , ,	Interval Betwee Onset and Deat	
disease or condition resulting in death)	· Marz	cardinal	TAR	VEGG.	14/720		26x	
	DUE TO (OR	S A CONSEQUENCE OF):				10	
Conventielly list conditions	b. Astry	050/450	to 1	test 1	D130834		315	
Sequentielly list conditions, if any, leading to immediate	DUE TO (OR A	S A CONSEQUENCE OF):				LP.	
cause. Enter UNDERLYING CAUSE (Disease or Injury	· DIAb	S A CONSEQUENCE OF	0/10/03				1-13	
that initiated events resulting in death) LAST	DOE TO (ON A	IS A CONSEQUENCE OF):					
	d							
PART II. Other significent condition	ns contributing to deat	h but not resulting l	n the underlyin	g ceuse given in	Part I. 24a. WAS AN		4b. WERE AUTOPSY FINDINGS	
					1 TYES		AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?	
						7	1 YES 2 NO	
DID TOBACCO USE CONT	RIBUTE TO CAUSE	OF DEATH YE	S NO [UNCERTAIL	N 🗆			
25. WAS CASE REFERRED TO MEDICAL		26. PLACE OF DEAT	H (Check only one)					
	HOSPITAL:	Outpatlant 3 DOA	OTHER: 4 Nursing Hon	ne 5 Residence	6 Other (Specify)			
EXAMINER?	27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 28c. INJURY AT WORK? M 1 YES 2 NO				28d. DESCRIBE HOW	INJURY OCCURED		
1 VES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending		T Neckdent 28e. PLACE OF INJURY — At home, tarm, street, fectory, office 28t. LOCATION (Street and Number or Rural Route Number, City or Town, State)						
1 Ves 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be	28e. PLACE OF INJ building, etc. (URY — At home, term, a Specify)	treet, rectory, orne		City or Town, State)		
1 Ves 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending Investigation 3 Suicide 6 Could not be determined 29a. CERTIFIER (Check only	28e. PLACE OF INJ building, etc. (: SICIAN: To the best of my ki	nowledge, daath occurre	od at the time, date	and place, end due	City or Town, State	nner as stated.		
1 Ves 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending Investigation 3 Suicide 6 Could not be determined 29a. CERTIFIER (Check only	building, etc. (nowledge, daath occurre	od at the time, date	and place, end due	City or Town; State to the cause(e) end ma time, date and place, et	inner as stated.		
1 VES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending Investigation 3 Suicide 6 Could not be determined 29e. CERTIFIER (Check only one) 1 VES 2 NO 27. MANNER OF DEATH 1 CERTIFYING PHY: 1 MEDICAL EXAMIN	building, etc. (: SICIAN: To the best of my ki IER: On the basic of axamin	Specify) nowledge, dasth occurre ation end/or investigatio	od at the time, date	and place, end due lesth occured st the	city or Town, State to the cause(e) end ma time, date and place, et	inner as stated.	e(e) end manner as stated.	

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1995

3. TIME OF DEATH

11:35A

REG NO

vecember 5,

2. DATE OF DEATH

FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

John

Dugan

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4. SOCIAL SECURITY NUMBER 5. SEX IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year, 6. AGE (In yrs. last birthday) 8. BIRTHPLACE (State or Foreign DAYS HOURS 1 X M 2 F 218-16-0403 69 10/29/26 Maryland 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH RECTOR permit, Pages 1, 2, 3 Doctor's Hospital of P.G. Lanham Brince George's RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Md. P.G. Riverdale $\overline{\Box}$ 1 X YES 2 NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g, CITIZEN OF WNAT COUNTRY? 5417 55th Pl. funeral director, page 5 should be detached for use as the burial-transit 20737 U.S.A. retained by the hospital or attending physician. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 X YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or Noif yes, specify Cuban, Maxican, Puarlo Rican, atc.) 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Married 1 YES 2 XNO Specify BY 3 Widowed 4 Divorced Specify: Black WW II ETED. 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only high College (1-4 or 5+) Elementary/Secondary (0-12) COMPL yr. Supervisor-Med.Records U.S.Government 17. FATHER'S NAME (First, Middle Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) To John Sellers BE Gladys Wallace notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 John D. Sellers, Jr. 711 49th St., N.E. # 4, Wash., D.C. 20019 hours after death. Page 6 may be 9 20b. PLACE AND DATE OF DISPOSITION (Name of must 20c. LOCATION - City or Town, State 12/11/95 Cheltenham Vet's. Cem. Cheltenham, Md. 4 Donation 5 Other (Specify) 22. NAME AND ADDRESS OF FACILITY
H.S. Washington & Sons, Inc.
4925 Burroughs Ave., N.E. examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Scatt W. and completely filled in by the burial, cremation, or removal. the medical 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrest, Approximata ahock, or heart fallure. List only one cause on each line Interval Betwe IMMEDIATE CAUSE (Final Onset and Daeth disease or condition resulting in death) MRDID RUCHONAXY

DUE TO (OR AS A CONSEQUENCE OF): MRKETT MINUERS event. OROMARY ARTENY DISEASE other traumatic CERTIFICATION 4EBN1 Sequentially list conditions. DUE TO (OR AS A CONSEQUENCE OF): ene prior to if any, leading to immediate cause. Enter UNDERLYING certificate has been signed by the attending physician in the State Dept, of Health and Mental Hygiene prior to the death certificate be DUE TO (OR AS A CONSEQUENCE OF): LESUL CAUSE (Disease or injury that initiated events resulting in death) LAST MONTH ACNOTRITION PART II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. MEDICAL 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 24a. WAS AN AUTOPSY requires that any BNCEN 1 TES 2 NO OF DEATH? 1 TES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \square NO \square UNCERTAIN \square PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) 1 YES 2 NO HOSPITAL OTHER: ATTENDING PHYSICIAN: itlant 2 DER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Rasidence 8 ☐ Other (Specify) ö 27. MANNER OF OEATH 28b. TIME OF 28a. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT marked, 28d. DESCRIBE HOW INJURY OCCURED with this Natural 5 Pending Investigation 1 YES 2 NO BY After death 2 Accident 3 Suicide 28s. PLACE OF INJURY — At home, term, street, factory, office building, atc. (Specify) 28 is 28t. LOCATION (Street and Number or Rural Route Number, City or Town, State) DIRECTOR: / COMPLETED 4 Homleide 98 29a. CERTIFIER CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. TO THE HOSPITAL O TO THE FUNERAL DI Se filed within 72 ho examination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(a) and manner as stated. 296, SIGNATURE AND TITLE OF CENTIFE BE 29c LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) 31069 Z 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) George Bone M.D., 9602 Martin Luther King Jr. Hgy., Lanham, MD 20706 32/REGISTRIAR'S SIGNATURE DHMH-18 Rev 1/89

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

Sellers, Sr.

M. C. Carlotte and C. C. Carlotte and C. C. Carlotte and C. C. Carlotte and C. C. Carlotte and C. C. Carlotte and C. Carlotte

1995

9c. COUNTY OF DEATH

Prince George's

10g, CITIZEN OF WHAT COUNTRY?

United States

REG. NO. 2. DATE OF DEATH DAY

FOR STATE REGISTRAR

1 DECEDENT'S NAME (First Middle Last)

KATHERINE

30 NOVEMBER 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Yee MONTHS DAYS HOURS MIN. 1 M 2 XXF 577 01 0873 87 Jan. 8,1908 Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATN DIRECTOR Prince George's Hospital Cheverly RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION Maryland Prince George's Rowie permit. 100. STREET AND NUMBER FUNERAL 101, ZIP CODE use as the burial-transit 12805 Bellhurst Lane 20715 Page 6 may be retained by the hospital or attending physician. 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-FORCES? 1 YES YENO If yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 Never Merried 2 Merried 1 YES 2 X NO Specify: ΒY % Widowed 4 □ Divorced ED 18e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only high COMPLET funeral director, page 5 should be detached for Elementary/Secondary (0-12) College (1-4 or 5+) 8 Homemaker Own Home 17. FATNER'S NAME (First, Middle, Last) 18. MOTNER'S NAME (First, Middle, Melden Surname) notified at John Kuhn Christine Fisher BE 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 John Gilbert Hazel Jr. 12805 Bellhurst Lane Bowie Maryland 20715 Pe 20s. METHOD OF DISPOSITION

XX Burtel 2 Cremetion 3 Removal from State 20h PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State DATE must metery crematory or other place) Cedar Hill Cemetery 12/4/95 Donation 6 - Other (Specify) Suitland Maryland examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Robert E. Evans Funeral Home, P.A. filled in by the fu 16000 Annapolis Rd. Bowie Md. 20715 23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, abock, or heart fellure. List only one ceuse on each line. medical IMMEDIATE CAUSE (Final Congestive Ment Fallie

Due to (or as a consequence of): the disease or condition signed by the attending physician and completely in Health and Mental Hygiene prior to burial, crematic resulting in death) event. DUE TO (OR AS A CONSEQUENCE OF): traumatic CERTIFICATION Sequentially list conditions, If any, leading to immediate cause. Enter UNDERLYING HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 10 PART II. Other aignificent conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY MEDICAL any 1 TYES 2 THO shows ; been f. of I has be Dept. (DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: 23 26. PLACE OF DEATH (Check only one) 25. WAS CASE REFERRED TO MEDICAL certificate to the State I, or Item EXAMINER? HOSFITAL: OTHER:
4 Nursing Nome 5 Residence 8 Other (Specify) 1 YES 2 NO Inputient 2 - ER/Outputient 3 - DOA 27. MANNED OF DEATH 28e. DATE OF INJURY 28b. TIME OF INJURY 28c. INJURY AT WORK? 26d. DESCRIBE NOW INJURY OCCURED marked, this c Natural 5 Pending 1 YES 2 NO DIRECTOR: After the hours after death vitem 28 is mari BY Investigation Accident 26e. PLACE OF INJURY — At home, farm, streat, fectory, office building, etc. (Specify) 3 Suicide 261. LOCATION (Street and Number or Rural Route Number, City or Town, State) 6 Could not be COMPLETED 4 Homicide determined 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data end piece, and due to the cause(s) end menner as stated. TO THE HOSPITAL TO THE FUNERAL I be filed within 72 h important. If ii 2 MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) end menner as stated. 296. SIGNATURE AND TITLE OF CENTIFIER 29c, LICENSE NUMBER BE 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 323/ Sugaria-Pa-37

32. RESISTRAP'S SIGNATURE

31. DATE FILED (Month, Day,

DEC

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

STUART

3. TIME OF DEATH

8. BIRTHPLACE (State or Foreign Country)

Washington D.C.

10d. INSIDE CITY

14. RACE — American Indien, Black, White, etc.

TYPES 2 NO

White

Approximata Interval Between Onset and Death

24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE

1 | YES 2 | NO

OF DEATN?

29d. DATE SIGNED (Month. Day, Year)

Yers

10:15P

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30. NAME AND ADDRESS OF PERF 31. DATE FILED (Month, Day, Yell) DEC 8

8 1995

	FOR	STATE OF MARYLA	ND / DEPAR	RTMENT N	E HEAITH AND I	MENTAL HYCLE		5 3	8496	
	1 - STATE REGISTRAR 1. DECEDENT'S NAME (First, Middle, La	st)			OF DEATH	REG. N	0.		TIME OF DEATH	
	Richa	id Alan		Sharp		December	5. 19	95	10:30A M	
	4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE (In	yrs. last birthday)	IF UNDER 1 YE		2 DATE OF BIRTH			CE (State or Foreign	
	213-44-4562	1 (X M 2 □ F 51	YAS.	MONTHS DA	YS HOURS MIN.	July 12,	1944	New	York	
OR	90. FACILITY NAME (If not institution, go Doctors Communi	ty Hospital		96. CITY, TOT Lank	WN OR LOCATION OF DE	EATN		TY OF DEATH		
DIRECTOR	RESIDENCE OF DECEDENT 100. STATE 10b. COU Maryland Pri			ry, town on L					I. INSIDE CITY LIMITS?	
FUNERAL D	100. STREET AND NUMBER 71C Ridge Roa			0011001	101, ZIP CODE 20771		100	EN OF WHAT	YES 2 NO	
N N	11. MARITAL STATUS	12. WAS DECEDENT EVER IN	I C ADMED	40 3400				S.A.		
BY	1 Never Married 2 Merried 3 Wildowed 4 Divorced	FORCES? 1 YES	2 NO	if yes	DECENDENT OF NISPAI s, specify Cuban, Maxica YES 2 NO Specify	n, Puerto Rican, etc.)	es or No—	Black, Wh	American Indian, hila, atc.	
G .	15. DECEDENT'S (Specify only highest g	EDUCATION ade completed)	16a. DECEDENT'S	USUAL OCCU	PATION or most of working	16b. KIND OF B	USINESS/INDU	JSTRY		
COMPLET	Elementary/Secondary (0-12)	life. Do NOT u	(Give kind of work done during most of working life. Do NOT use retired.) Unknown Unknown							
BE COI	17. FATNER'S NAME (First, Middle, Lest) Charlton D. Sh	arp			18. MOTHER'S NA Susant	ME (First, Middle, Meide ne Rowder				
TO B	19a. INFORMANT'S NAME (Type/Print) Carlton J. Shi	arp			Drive, Spr			Code) 22153		
20s. METNOD OF DISPOSITION 1 Burlet 2 M Cremetton 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION Name of DATE 20c. LOCATION — City or Town Location City or Town Location City or Town Location Location Location City or Town Location Loca									State	
	22. NAME AND ADDRESS OF FACILITY Rencon/Halle Funeral Home 9013 Annapolis Road, Lanham, MD 20706									
	22. PART I Enter the diseases, shock, or heart fellu IMMEDIATE CAUSE (Final disease or condition results to in death)	a. A CMA. DUE TO (OR AS A C	ch line.					eat,	Approximate interval Between Onset and Death	
ERTIFICATION	Sequentielly list conditiona, if any, leading to Immediate cause. Enter UNDERLYING CAUSE (Disease or Injury									
	that initiated evente peauting in death) LAST DUE TO (OR AS A CONSEQUENCE OF):									
LC	PART ii. Other significent condi	tione contributing to deeth but	t not resulting	in the under	riying ceuse given in		AN AUTOPSY		RE AUTOPSY FINDINGS	
MEDICAL	Hypo	tensor				1 YES	ORMED? 2 ☑ NO	COI OF	MABLE PRIOR TO MPLETION OF CAUSE DEATH? YES 2 NO	
PHYSICIAN: MEDICAL	DID TOBACCO USE CO 25. WAS CASE REFERRED TO MEDICA EXAMINER?	NTRIBUTE TO CAUSE OF HOSPITAL:	B. PLACE OF DEA	ES NO		N D				
YSI	1 TYES 2 NO	1 € Inpatient 2 □ ER/Outpat		4 🗆 Nursing	Nome 5 Residence	8 Other (Specify)				
ву Рн	27. MANNER OF DEATN 1 Nsturel 5 Pending 2 Accident Investigati	28e. DATE OF INJURY (Month, Day, Year)	28b. Till IN	JURY	E. INJURY AT WORK? YES 2 NO	28d. DESCRIBE NOV	V INJURY OCC	URED		
0	3 Suicide 8 Could not		At home, term,	street, fectory,	office	281. LOCATION (Stree City or Town, Sta		or Rural Route	Number,	
COMPLET	one)	IYSICIAN: To the best of my knowle							d manner as stated.	
띪	29b. SIGNATURE AND TITLE OF CERT	FIER DY A 110			29c. LICENSE NU	MBER	29d. DATE	SIGNED (Mo	onth, Day, Year)	
TO BE COI	30. NAME AND ADDRESS OF PERSON	WHO COMPLETED CAUSE OF DEAT	TH (ITEM 27) (Type	e, Print) d	17 2424 Rend	1		- 0	7()	
	M- Just,	4.0. 3450 Fo	stm	endi	Kond	laurel	MD.	207	27	

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FOR

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the tuneral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

DIVISION OF VITAL RECORDS, P.O. BOX 68760

IMPORTANT: If item 28 is marked, or item 23 shows any Injury, or other traumstic event, the medical examiner must be notified at once.

BALTIMORE, MARYLAND 21215-0020

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	1 - STATE REGISTRAR		CE	RTIF	ICATE OF	DEATH	F	REG. NO.			
	1. DECEDENT'S HAME (First, Middle, Last)						2. DATE OF	DEATH DAY	MEAN	3. TIME OF DEATH	
	John	Wilmer	Savin,	Sr			10VEW	ber 30 1	995	3 05 1	
	4. SOCIAL SECURITY NUMBER 216-28-5779	5. SEX 1 X M 2 \square F	6. AGE (In yrs. lest	birthday) YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF I	BIRTH	_	IPLACE (State or Foreign	
TOR										eath Cil	
DIRECTOR	RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY MD		10c. CIT	Y, TOWN OR LOCA	re de Gr	200			10d, INSIDE CITY LIMITS? 1 YES 2 X NO		
	100. STREET AND NUMBER 1709 Level Ro				. ZIP CODE	078	10g. CIT	WHAT COUNTRY?			
BY FUNERAL	11. MARITAL STATUS 1 Never Merried 2 Merried 3 Wildowed 4 Divorced	11. MARITAL STATUS 1 Never Married 2 Merried 12. WAS DECEDENT EVER IN U.S. AI FORCES? 1 YES 2 X IF YES GIVE WAR OR DATES						specify Yes or Ho— n, etc.)	14. RACI	E — American Indian, k, White, etc.	
COMPLETED		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (8-12) College (1-4 or 5 +) 16a. DECEDENT'S USUAL OCCUPATIOH (Give kind of work done during most of working life. Do NOT use retired.) 18b. KiHD OF BUSINESS/INDUSTRY									
	17. FATHER'S HAME (First, Middle, Lest) John Holder	Savin						le, Maiden Surneme) urkentine	e		
) BE	19e. INFORMANT'S NAME (Type/Print)		196.	MAILING	ADDRESS (Street			City or Town, State, Z			
10	Mr. John W. Savi	n, Jr.	4	015	Shari L	ynn Dr.	, Abir	ngdon, N	1D 2	21009	
	20e. METHOD OF DISPOSITION 1 Surial 2 Cremation 3 Remo 4 Donation 5 Other (Specify)	vel from State	cemetery, crem	AHD DATE OF DISPOSITION (Name of parties) AND DATE OF DISPOSITION (Name of parties) AND DATE OF DISPOSITION (Name of parties)					LOCATION — City or Town, State		
	Rock Run Cemetery 12/5 Havre de Grace, MD 21. SIGNATURE OF FUHERAL SERVICE LICENSEP Mitchell-Smith Funeral Home, P.A.										
-92	Villain	X. D.	A	+				MD 2107			
z	shock, or heart feiture. L IMMEDIATE CAUSE (Finel disease or condition resulting in death)	disease or condition									
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Entar UNDERLYING CAUSE (Disease or Injury that Initiated eventa resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):										
MEDICAL C	PART ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 24s. WAS AN AUTOPSY PERFORMEDY 1 VES 2 NO								241	. WERE AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO	
	DID TOBACCO USE CONTR	IBUTE TO CA	USE OF DEAT	H Y	ES NO [UNCERTAI	N 🗆				
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO	HOSPITAL:	26. PLACE ER/Outpatient 3		OTHER:	ne 5 🗆 Residence	6 Other /S	maniful			
	27. MAHHER OF DEATH 1 Netural 5 Pending	INJURY lay, Year)	28b. TII	ME OF 28c. IN	JURY AT DRK? YES 2 HO		IBE HOW INJURY O	CCURED			
TED BY	2 Accident investigation 3 Suicide 8 Could not be determined	26a. PLACE C building,	26s. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify)				281. LOCATION (Street end Number or Rural Route Number, City or Town, State)				
COMPLET	(Orack Oray	(Check only 1 2 CENTIFYING PATSICIAN: to the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) end manner es stated.									
8	296, SIGNATURE AND TITLE OF CERTIFIER	296. SIGNATURE AND TITLE OF CERTIFIER Sachus M.D. 296. LICENSE NUMBER D.23322 > 11/. 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Typo, Print) S. S. SACHDEN M.D., 118 Neghtist Sact 313 Elik Com 1402/93 31. Date filed (Month, Day, Your) 32. REGISTRARYS SIGNATURE P. 11								(Month, Day, Year)	
2	30. NAME AND ADDRESS OF PERSON WHO S. S. SACHDE	COMPLETED CAU	SE OF DEATH (ITEM	127) (MP	Saile	313 6	CKG	N 12021	1921		
	31. DATE FILED (Month, Day, Year) DEC 0 1 199	5 Julia	ARYS SIGNATURE	ardal	u						

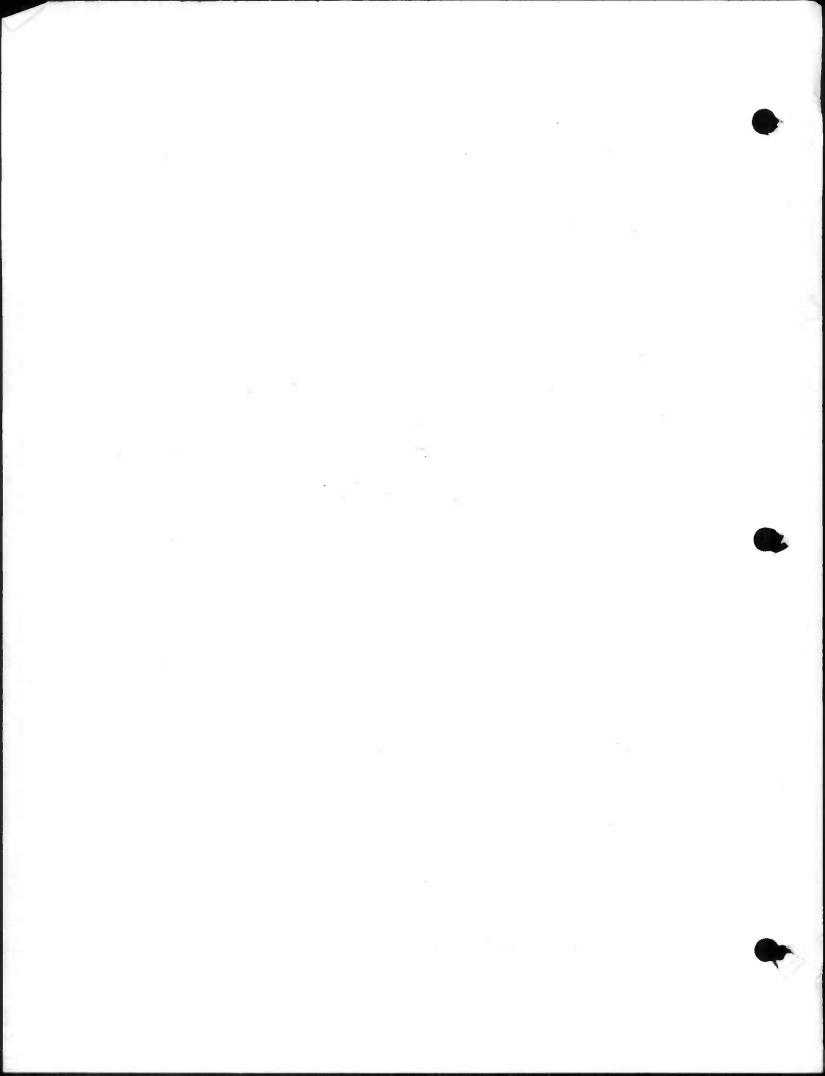
ours after death. Page 6 may be retained by the hospital or attending physician. BALTIMORE, MARYLAND 21215-0020

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aw requires that the death certificate be executed within dours after death. Page 6 may be relatined by the hospital or attending physician.	s been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should	tion, or removal.	the medical examiner must be notified at once.
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed wit	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and comple	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to builal, cremation, or removal.	IMPORTANT: It item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	1 - STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.										
	1. DECEDENT'S NAME (First, Middle, Last)	2.	DATE OF DEATH	3. TIME OF DEATH							
	Lottie JOHNSON Slacum		Dec 3 1995 4:20 A								
	4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 $216-16-7284$ 1 \square M 2 \square XF 71 YRS. MONTHS	DAYS HOURS MIN.	DATE OF BIRTH (Month, Day, Year) AR _ 31 _ 1924	8. BIRTHPLACE (State or Foreign Country) MARYLAND							
	9e. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH										
DIRECTOR	The Pines Easton Talbot										
DIRE	MARYLAND 106. COUNTY 106. CITY, TOWN OR	LOCATION EASTON		10d. INSIDE CITY LIMITS? 1 X YES 2 NO							
IAL	10e. STREET AND NUMBER	101. ZIP CODE	CITIZEN OF WHAT COUNTRY?								
FUNERAL	RT. 50 & DUTCHMAN'S LANE 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECEDENT EVER IN U.S. ARMED	21601		USA							
BY	1 Never Merried 2 Merried FORCES? 1 YES 2 XNO If	AS DECENDENT OF HISPANIC Or yes, specify Cuben, Mexican, Pu YES 24 NO Specify:		- 14. RACE — American Indian, Black, White, etc. Specify: WHITE							
9	15. DECEDENT'S EDUCATION (Specify only highest grade completed) 18a. DECEDENT'S USUAL OCC (Give kind of work done du	CUPATION ring most of working	16b. KIND OF BUSINESS	/INDUSTRY							
COMPLET	Elementary/Secondary (0-12) College (1-4 or 5 +) College (1-4 or 5 +) OWNER		MOVING	COMPANY							
SON	17. FATHER'S NAME (First, Middle, Last)	16. MOTHER'S NAME (First, Middle, Melden Sumerr	ne)							
BE (McCULLOUGH JOHNSON		YRINE MII								
2		Street and Number or Rural Route ASHINGTON S									
13	20s. METHOD OF DISPOSITION Buriel 2 Cremetion 3 Removal from State	1	20c. LOCATION 2-5 CAMBI								
		AME AND ADDRESS OF FACILIT	TY								
	JOHN R MERIERAN CESP 20	WNAM FUNERA O S. HARRIS	SON ST., I	EASTON, MD							
	23. PART I. Enter the diseases, or complications that caused the death. Do not enter the shock, or heart fellure. List only one cause on each line.	he mode of dying, auch as	cerdiac or reepiratory	Approximata interval Between							
	IMMEDIATE CAUSE (Finel disease or condition resulting in death) a. HDRs CIPITALUS J DUE TO (OR AS A CONSEQUENCE OF):	BRMN A	TROPITY	Onset and Death							
z											
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING										
EIC.	CAUSE (Disease or injury that initiated events DUE TO (OR AS A CONSEQUENCE OF):										
ERT	resulting in deeth) LAST										
AL C	PART II. Other aignificent conditions contributing to deeth but not resulting in the und	erlying cause given in Part									
200	0.6		PERFORMED?	COMPLETION OF CAUSE							
PHYSICIAN: MEDIC	PNEUTIONIA			1 TES 2 NO							
AN	25. WAS CASE REFERRED TO MEDICAL	28. PLACE OF DEATH (Check of	only one)								
SIC	HOSPITAL: 1 PES 2 NO 1 Inpetient 2 ER/Outpetient 3 DOA 4 Nursh	ng Home 5 Reeldence 8									
	27. MANNER OF DEATH 1 Netural 5 Pending 28. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY (Month, Day, Year)	8c. INJURY AT WORK?	d. DESCRIBE HOW INJURY	OCCURED							
ED BY	2 Accident investigation 3 Suicide 6 Could not be determined determined										
	29e. CERTIFIER (Check only 1. CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time										
COMPLET	(Check only one) 2 MEDICAL EXAMINER: On the best of examination and/or investigation, in my opinions.										
B	29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER		DATE SIGNED (Month, Day, Ner)							
임	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)		~ 1'	14711-							
	C.RW BAN 415 EDOL	TER, FAST	EN, PD	,2160/							
	31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE DFC 0.5 1995 Salia Stubber Revielle										
- 1	LIFE UN 1995 June 10 march 1995										





TO THE HOSPITAL, OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT. If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

FOR 1 STATE DEGISTRAD STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

HEGISTHAR	CENTIFIC	AILO	PEAIN	HEG. NO.						
1. DECEDENT'S NAME (First, Middle, Last)				2. DATE OF DEATH DAY	YEAR	3. TIME OF DEATH				
OLIVER	Dec. 2 1995 11:47 pM									
4. SOCIAL SECURITY NUMBER 217-12-4335A 5. SEX 8. AGE (In yi		UNDER 1 YEAR	HPLACE (State or Foreign ARYLAND							
9e. FACILITY NAME (If not institution, give stree' end number)	98	. CITY, TOW	N OR LOCATION OF DEA	TH 9	c. COUNTY OF					
MEMORIAL HOSPITAL RESIDENCE OF DECEDENT 100. STATE 100. COUNTY MARYLAND TALBOT		EA	STON		TALBOT					
RESIDENCE OF DECEDENT 100. STATE 10b. COUNTY	10c. CITY, T	OWN OR LO	CATION			10d, INSIDE CITY				
	EA	STON				1 X YES 2 NO				
100. STREET AND NUMBER 17 PLUM STREET 11. MARITAL STATUS 1 Never Married 2 M Married 17 PROPER 1 1 YES 2			10f, ZIP CODE 21601	1	10g. CITIZEN OF WHAT COUNTRY? USA					
11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced 12. WAS DECEDENT EVER IN U. FORCES? 1 YES 2 IF YES, GIVE WAR OR DATE:	NO	If yea,	ecendent OF HISPANIC specify Cuben, Mexican, ES 2 NO Specify:	C ORIGIN? (Specify Yes or Puerto Ricen, etc.)	s or No— 14. RACE — American Indian, Black, White, etc. Specify.					
The state of the s	ie. DECEDENT'S USI	UAL OCCUPA	ATION most of working	16b. KIND OF BUSIN	SS/INDUSTRY					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 10 17. FATHER'S NAME (First, Middle, Last)	life. Do NOT use re	tired.)	most or working							
10	PLUM	IBER		PLUMB						
17. FATHER'S NAME (First, Middle, Last)				E (First, Middle, Maiden Sur	name)					
CHARLES M. SATCHELL	I se stare a		ALICE							
O I 198. INFORMANT S NAME (1/portini)				oute Number, City or Town, S		0.1				
CLUTTEDA CATHERINE SATCHE	ACE AND DATE OF C				ION — City or					
			RIAL PAR		ASTON .					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE		NEW	NAM FUNE	RAL HOME,	P.A.					
JOHN Z. MERCERON										
23. PART I. Enter the diseases, or complications that caused the	23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. IMMEDIATE CAUSE (Final									
resulting in death) a. DUE TO (OR AS A CO	ONSEQUENCE/OF):	W-24	eym	. 1		10) viene				
- ASHN WU	the chris	vii a	trial Lelin	llate Ch	4=	3cm				
Sequentially list conditions, if any, leading to immediata	Sequentially list conditions, DUE TO (OR AS A CONSCIUENCE OF)									
S cause. Enter UNDERLYING CAUSE (Disease or Injury										
that initiated events	ONSEQUENCE OF):									
resulting in death) LAST										
The second state of the se	not resulting in	the underl	ring cause given in F	Part I. 24a. WAS AN AU	TOPSY 24	1b. WERE AUTOPSY FINDINGS				
Dialites Mellifus With	neuro			PERFORME	:0?	AVAILABLE PRIOR TO COMPLETION OF CAUSE				
		1 PYES			LNO	OF DEATH?				
DID TOBACCO USE CONTRIBUTE TO CAUSE OF	DEATH VES	□ NO	NV UNCERTAIN			1 YES 2 NO				
25. WAS CASE REFERRED TO MEDICAL 26.	PLACE OF DEATH									
EXAMINER? 1 YES 2 NO 1 Inpetient 2 ER/Outpatk		THER:	fome 5 - Residence 6	I Char (Speciful						
27. MANNEY OF DEATH 280. DATE OF INJURY	28b. TIME C	OF 28c.	INJURY AT	28d. DESCRIBE HOW INJ	JRY OCCURED					
1 Netural 8 Pending (Month, Day, Year) 2 Accident (Month, Day, Year)	INJUR		WORK? YES 2 NO							
3 Suicide 8 Could not be building, atc. (Specify)	At home, ferm, stre	street, factory, office 281. LOCATION (Street end Number or Rural Route Number, City or Town, State)								
29e. CERTIFIER Chock cold. CERTIFYING PHYSICIAN: To the best of my knowled	de death necumed	et the time	teta and place, and due t	to the cause(s) and manne	r as stated					
29e. CERTIFIER (Check only one) 29 MEDICAL EXAMINER: On the best of my knowled one) 2 MEDICAL EXAMINER: On the best of examination ending the control of examination ending th						e(e) end menner se stated.				
296. SIGNATURE AND TITLE OF CERTIFIER	MA		29c. LICENSE NUM		9d. DATE SIGNI	SS SS				
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH			•							
WILLIAM H. WOOD, JR., M	I.D.,50	6 ID1	LEWILD AV	ENUE, EAS	TON,	MD 21601				
DEC 05 1995	UBE .									
DEC 05 1995 July all water	rantially									

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	after death. Page 6 may be retained by the hospital or attending physicia
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FOR STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	_	REGISTRAR		CERTI	ICATE C	F DEATH	REG. NO.			
		1. DECEDENT'S NAME (First, Middle, Last)						2. DATE OF DEATH S. TIME OF DEATH MONTH DAY YEAR A COLOR		
v		Hilda Grace Stone					Dec. 0	6, 1995	1230 m	
				(In yrs. last birthday)	MONTHS DAY		7. DATE OF BIRTN (Month, Day, Year)	8. BIRTH Country	PLACE (State or Foreign	
pin			1 □ M 2 🔀 F	90 YRS.			Feb. 22,		yland	
3 should	<u>~</u>	9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH								
c/i	Ē	716 William Avenue Westminster Carroll								
0es 1	DIRECTOR	10a. STATE 10b. COUNTY		10c, CI	TY, TOWN OR LO	CATION			10d. INSIDE CITY	
. <u></u>	a	Maryland Carro	11		Westmi	nster			LIMITS? 1 YES 2 NO	
De El	\¥	10e. STREET AND NUMBER				10f. ZIP CODE		10g. CITIZEN OF W	NAT COUNTRY?	
ansit	VER	716 William Avenu	e				21157	Un	ited States	
020 physician. burlat-transit permit. Pages 1,	FUN	11. MARITAL STATUS 1 Never Married 2 Married	12. WAS DECEDENT EVER FORCES? 1 YES	IN U.S. ARMED	13. WAS	DECENDENT OF NISPAI , specify Cuban, Maxica	NIC ORIGIN? (Specify Yes	or No- 14. RACE Black	- American Indian, White, etc.	
9 8 8	B	3 Wildowed 4 Divorced	IF YES, GIVE WAR OR	DATES		YES 2 NO Specifi		Specif	y:	
r attendi	E	15. DECEDENT'S EDUCA		16a, DECEDENT'S	S USUAL OCCUP	ATION	165 KIND OF BUILD	SINESS/INDUSTRY	White	
212 alora for us		(Specify only highest grade of Elementary/Secondary (0-12)	College (1-4 or 5+)	(Give kind of life. Do NOT	work done during	most of working	Too. King or so.	JANESS/IIVO GOTAT		
	필	8		Homema	aker		Ow	n Home		
AND 21 the hospital or detached for u	COMPLET	17. FATHER'S NAME (First, Middle, Last)				18. MOTNER'S NA	ME (First, Middle, Maiden	Surname)		
2 2 2 x	BE	John Harvey Barbe	r					le Harris	3	
MARYLAND retained by the hospit 5 should be detached notified at once.	0	19a. INFORMANT'S NAME (Type/Print) Charles E. Stoner					Route Number, City or Town			
							Westminste	er, MD 21	L57	
ORE, e 6 may be ector, page must be		20a. METHOD OF DISPOSITION 1 ☐ Burial 2 ☐ Cremation 3 ☐ Ramov	mil from State 20	b. PLACE AND DATE	OF DISPOSITION	(Name of 12/0 h Cemetery	9/8/5E 20c. LO	CATION — City or Tov		
Page (4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE-LICES		Meadov				stminster	r, MD	
BALTIMORI er death. Page 6 may the funeral director, p val.		21. SIGNATURE OF FUNERAL SERVICE-LICENSEE 22. NAMPAPI CLESS PURE LA Home & Chapel 412 Washington Rd., Westminster, MD 21157								
BALTIMORE, after death. Page 6 may be noval. noval.		week of war 15								
in by remcedic		23. PART I. Enter the disasses, or complications that caused the deeth. Do not enter tha mode of dying, such as cerdiec or respiratory arrest, abock, or heart failure. List only pric cause on each line. Approximate interval Between								
7 E C 9		IMMEDIATE CAUSE (Final disease or condition) AP 2 AD ANUAR COLOR OF THE COLOR OF THE COLOR OF THE CAUSE (Final disease or condition)								
CB76C and completely fille of burial, cremation, matic event, the	1 1	resulting in death) a. OUE TO (DR AS A CONSEQUENCE OF):								
P 8 8 3	_		OUE TO (DR AS	A CONSEQUENCE ()F): \(\)		, ,	l		
OX 68 e be execut sician and c rtor to buris traumatic	CERTIFICATION	Sequentially list conditions, If any, leading to immediata DUE TO (OR AS A CONSEQUENCE OF):								
eath certificate be er attending physician and Hygiene prior to y, or other traum	3	CAUSE (Disease or Injury								
certificate nding physiene pr hygiene pr or other to	틸	that initiated events	DUE TO (OR AS	A CONSEQUENCE O	OF):					
S, P. death of death of attending ental Hy, or	HH	resulting in death) LAST								
0 0 0 5		PART II. Other algnificent conditions	contributing to death	but not resulting	in the underl	ying cause given in	Part I. 24s. WAS AN		WERE AUTOPSY FINDINGS	
00 = 55 -	EDICAL		orgent	ico He	20m	4. 4	PERFOR	MED?	MARABLE PRIOR TO COMPLETION DF CAUSE	
TO THE STATE OF	MEC					4			OF DEATH? 1 YES 2 NO	
C = 80 5	ä	DID TOBACCO USE CONTRI	BUTE TO CAUSE O	OF DEATH Y	ES NO	☐ UNCERTAIN	V DZ			
VITAL AN: The lav tificate has e State Dep	PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	28. PLACE OF DEA		ne)				
F VIT.	YSi		Inpetient 2 ER/Out	patient 3 DOA	OTHER:	tome 5 Thesidence	6 Other (Specify)		71	
PHYSICIAN: The this certificate hi with the State C infect of the control of the	PH	27. MANNER OF DEATH 1 Natural 5 Pending	28a. DATE OF INJURY (Month, Day, Year)	28b, TII	ME OF 28c.	INJURY AT WORK?	28d. DESCRIBE NOW IF	NJURY OCCURED		
ON OING PHYS After this death with	À	1 Natural 5 Pending 2 Accident Investigation				YES 2 NO				
DIVISION OR ATTENDING F DIRECTOR: After 1 hours after death Item 28 is mar	8	3 Suicide 6 Could not be 4 Homicide determined	28e. PLACE OF INJURY building, atc. (Spe	Y — At home, farm, icify)	street, factory, o	ffice	261. LOCATION (Street a City or Town, State)	and Number or Rural Ro	oute Number,	
DIVISION ATTEN DIRECTOR: hours after Item 28 lie	Щ	an appropria								
TAL O	MP	(Check only	AN: To the best of my know							
HOSPI Vithin	COMPLET	WEGICAL EXAMINER:	On the beels of examination	on and/or investigati	on, in my opinio	n, death occured at the	time, data and place, and	d due to the cause(s)	and manner as stated.	
TO THE HOSPITAL TO THE FUNERAL I De filed within 72 h IMPORTANT: If I	BE	296. SIGNATURE AND TITLE OF CERTIFIER	0	06.		29c. LICENSE NUN	MBER	29d. DATE SIGNED	Month, they, Year)	
2 6 % X	2	30. NAME AND ADDRESS OF PERSON WHO	COMPLETEO CAUSE OF DE	ATH (ITEM 27) (Type	Polosi C	10100	100	121	8 9	
		CHITRACUTA	-DUMA	EANN	A 7	00 A 4	ostone	el Wen	mines	
20		31. DATE FILED (Month, Day, Year)	32. HEGISTRAR'S SIGN	NATURE	,			771)	311	
		31. DATE FILED (MONIN, Day, 1687) DEC 0 8 1995	32. MEGISTHAR'S SIGN	or Revoluti					-	

